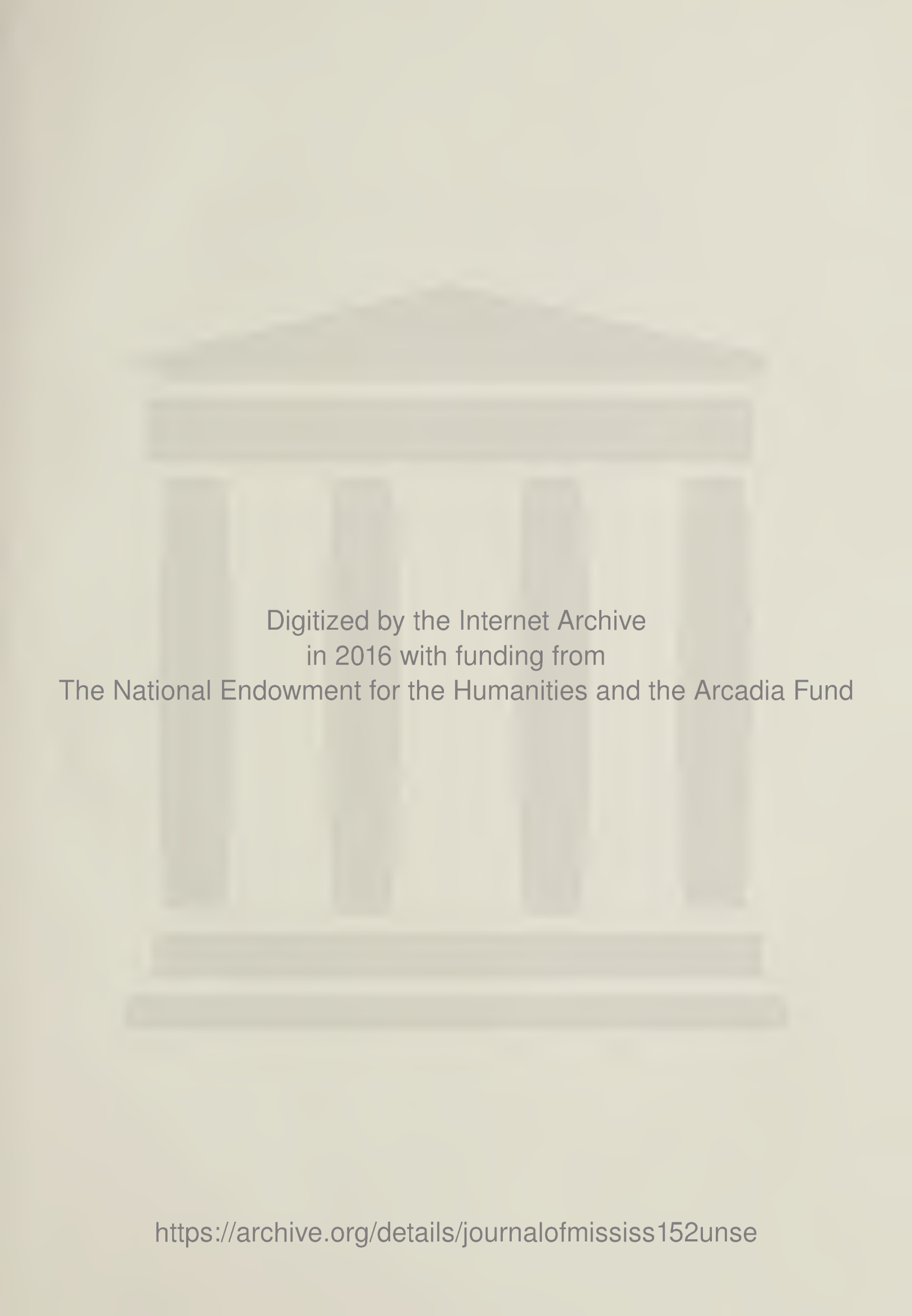
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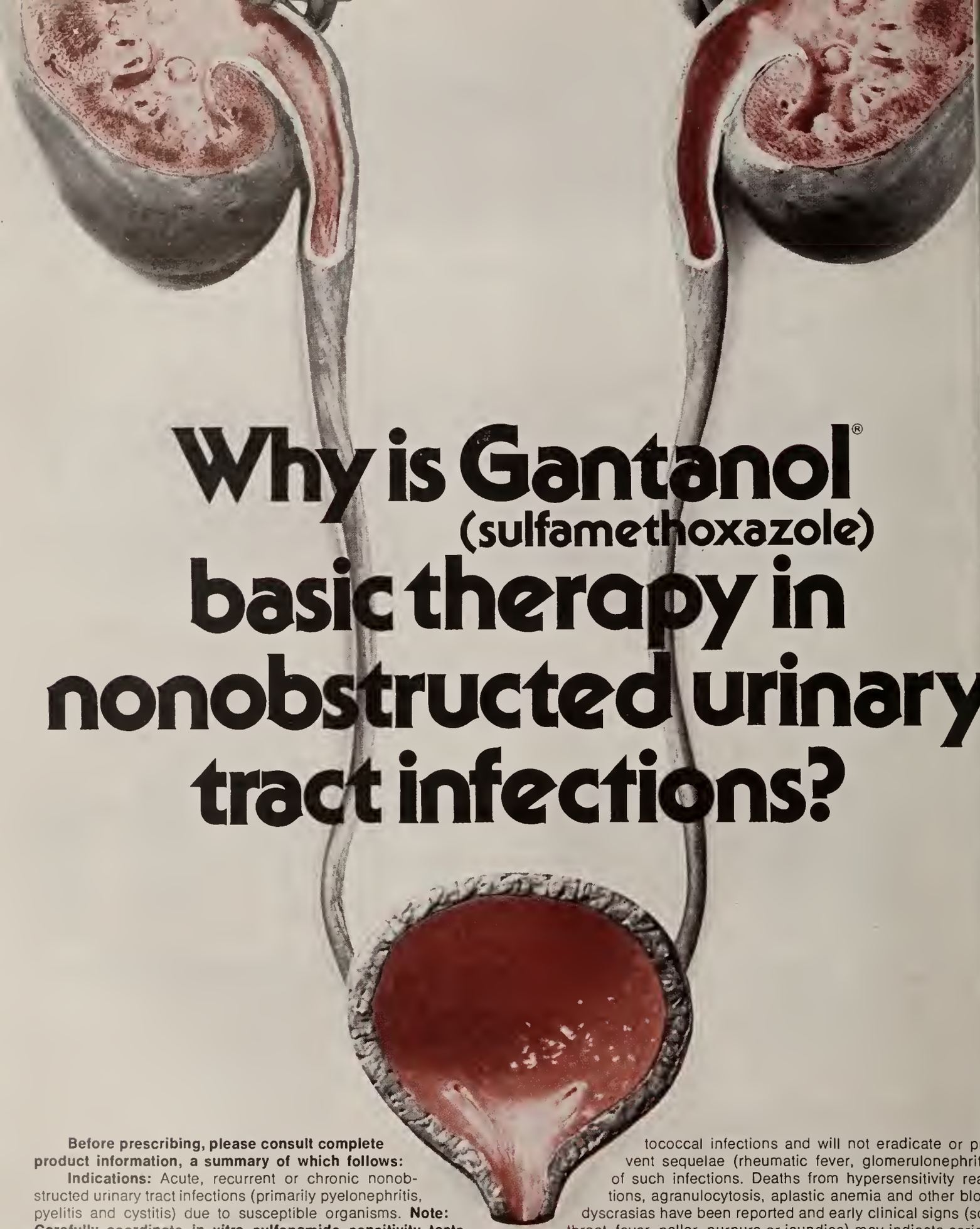
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Surgical Management of Postgastrectomy Syndrome

JOHN L. SAWYERS, M.D.
Nashville, Tennessee

Patients who have disturbances in their gastrointestinal physiology following gastric operations are diagnosed as having the "postgastrectomy syndrome." This syndrome encompasses a variety of pathophysiologic disorders including the dumping syndrome, the afferent loop syndrome, reflux gastritis, small gastric pouch syndrome, and postvagotomy diarrhea. The author discusses each of these, giving symptoms, etiology, and methods of treatment.

FOLLOWING OPERATIONS upon the stomach which impair normal gastric and pyloric functions, significant alterations occur in gastrointestinal physiology. Fortunately most patients have sufficient reserve to adjust to these changes without developing symptoms, but those patients with disturbances of their well-being following gastric operations are diagnosed as having the "postgastrectomy syndrome." A variety of pathophysiologic disorders have been grouped together in this "syndrome," but it is possible to differentiate between these disorders by careful diagnostic studies, especially by taking an accurate history from the patient.[1] Some of these disorders are mechanical in nature and require surgical intervention for correction while others are primarily physiologic in origin. But even these latter may respond to surgery.[2, 3]

The dumping syndrome is the most common postprandial complaint of patients who have undergone definitive operation for control of the complications of gastrointestinal ulcer disease. Dumping symptoms result from sacrifice of part of the stomach with its loss as a storage organ and from alteration or removal of the pyloric emptying mechanism.

Unfortunately, many different postgastrectomy disorders have been erroneously labeled dumping syndrome. An accurate history should delineate this disorder from other postgastrectomy syndromes. Symptoms of vasomotor imbalances manifested by weakness, faintness with an intense desire to lie down, palpitation, pallor and profuse perspiration are dominant while the gastrointestinal symptoms of postprandial cramping, abdominal pain and urgent diarrhea are less prominent. Ingestion of carbohydrates, especially sweet liquids, initiates these symptoms which are similar to the effects experienced by patients having an insulin reaction.

Most patients suffering from the dumping syndrome have mild, transitory symptoms. Dumping of mild to moderate degree may be fairly well controlled by dietary measures which limit carbohydrates and restrict fluid intake with meals. However, a few patients have severe dumping symptoms with resultant excessive weight loss, anemia, weakness, abdominal discomfort and occasional uncontrollable diarrhea. When restrictive measures with intensive

From the Department of Surgery, Vanderbilt University School of Medicine, Nashville, Tenn.
Presented before the Section on Surgery, Mississippi State Medical Association, Biloxi, May 7, 1974.

supportive treatment in the hospital fail to relieve the incapacitating symptoms of these patients, serious consideration should be given to remedial operation to prevent the patient from a life of invalidism.

Three different remedial operations have been utilized in the treatment of severe, intractable dumping syndrome. A comparison of the effectiveness of the isoperistaltic single jejunal segment, the double jejunal limb pouch and the antiperistaltic single jejunal segment interposed between the gastric pouch and duodenum has recently been reported.[4]

While the single interposed jejunal segment has been effective for patients with the afferent loop syndrome, it has not proved effective in our experience for alleviation of the symptoms of postprandial dumping. In 10 patients with an isoperistaltic jejunal interposition (Henley loop), there have been no excellent results.

Double plicated iso-antiperistaltic jejunal pouches, similar to those used for the small gastric pouch syndrome, have also been used in patients with postprandial dumping symptoms. These pouches tended to dilate and become sacculated over a period of a few years, and patients developed difficulty in gastric emptying. Jejunal pouch for dumping should be used only in patients who have had a very high (over 80 per cent) gastrectomy.

The most effective remedial operation for the dumping syndrome has been the use of single 10 cm. antiperistaltic jejunal segment interposed between the gastric remnant and duodenum. In 28 patients with severe, intractable dumping, 20 obtained an excellent result. These patients have either returned to their ideal weight or to within 10 pounds of their ideal weight. Six other patients have been improved by their remedial operation and are judged a good result. Only one patient was a poor result. She developed multiple ulcerations in her jejunal limb which was fashioned 18 cms long. Over a period of four years this excessively long (18 cm) segment, which was interposed between the gastric remnant and duodenum, became ulcerated and stenotic. It was removed and a shorter (8 cm) segment interpolated. The patient then gained 30 pounds and has been followed four years with an excellent result.

Obstruction has not occurred from use of 10 cm antiperistaltic segments; yet these reverse segments serve to delay gastric emptying by functioning as a substitute pylorus. Cineroentgenographic studies have been obtained at various time intervals in the follow-up period and show that reversed segments function effectively up to 10 years.

Remedial surgery for treatment of the dumping syndrome should be proposed only after all methods of conservative management have failed. Only patients who continue to have severe, intractable dumping symptoms while in the hospital on strict dietary regimens have been subjected to remedial surgery. For those few patients who are incapacitated with severe postprandial dumping, a single 10 cm antiperistaltic jejunal segment interposed between the gastric pouch and the duodenum is an effective remedial operation.

AFFERENT LOOP SYNDROME

The afferent loop syndrome depends upon the presence of an afferent loop and can occur only after gastrojejunostomy or resection of the Billroth II type. Pathogenesis consists of retention of biliary, pancreatic and duodenal secretions in the afferent loop at or near the gastrojejunal stoma. This may occur at any time in the postoperative period. Acute afferent loop obstruction developing a few days after surgery is characterized by severe epigastric pain, fever, tachycardia, nausea, vomiting and abdominal tenderness. If the condition is uncorrected by surgical intervention, the patient may lapse into shock. The obstruction is usually at the proximal stoma but may occur from acute kinking or torsion of a long afferent limb. Duodenal stump disruption or necrosis of the afferent limb may occur. Emergency surgery is necessary. Fortunately, this condition is very rare.

More often afferent loop syndrome is chronic, and the symptoms are intermittent. The patient complains of epigastric pain occurring within a few minutes to as long as an hour after eating. The pain is described as pressing, bursting or cramping and may radiate through the back in the interscapular region. Nausea then develops with vomiting which results in immediate relief of pain. The vomitus is voluminous in amount and consists of dark green or greenish brown bile which contains no recently ingested food. The most common cause is adhesions, but volvulus of a long afferent loop may occur as well as herniation through the transverse mesocolon or under the efferent loop.

The problem is purely mechanical and should not be confused with reflux bile gastritis or postprandial dumping syndrome. Reflux bile gastritis is not necessarily limited to a gastrojejunostomy anastomosis, but may occur after gastroduodenostomy or pyloroplasty and may be diagnosed by gastroscopy and

biopsy. Since no medical treatment is effective for afferent loop syndrome, surgical correction is mandatory for relief. A variety of operative procedures have been used but elimination of the afferent limb is preferred. This may be accomplished by conversion of a Billroth II to a Billroth I with or without an interposed Henley isoperistaltic jejunal segment. These procedures in 33 patients have given good to excellent results in all but three patients.

REFLUX GASTRITIS

Reflux gastritis, which is also termed bile gastritis or alkaline gastritis, is being recognized with increasing frequency. The condition generally develops in patients who have had previous operations for peptic ulcer disease although we have had two patients who had no prior surgical procedure. The diagnosis is made on the basis of symptoms (postprandial pain, bilious vomiting and weight loss), gastroscopy examination with biopsy and persistent hypochlorhydria. Remedial operations for correction of reflux is indicated in the presence of persistent symptoms when conservative measures fail. Only operative procedures which divert duodenal contents from the stomach or gastric remnant are effective. We have had experience with the isoperistaltic jejunal segment and the Roux-en-Y diversion.

Forty-seven patients have undergone remedial operation for reflux gastritis. There was no operative mortality. An isoperistaltic (Henley) jejunal segment interposed between the gastric reservoir and duodenum was used in 20 patients with good to excellent results in 18 patients. A Roux-en-Y procedure was done in 27 patients with satisfactory results in all. The Roux-en-Y operation is usually technically easier and provides equally good results as the interposed isoperistaltic segment.

The relief of abdominal pain and bile stained vomiting has been dramatic in these patients. The symptomatic improvement is also associated with improvement in the endoscopic appearance of the gastric mucosa.

Remedial operation for reflux gastritis is very effective in relieving this distressing condition and merits a greater awareness by gastroenterologists and surgeons.

The small gastric pouch syndrome occurs after high subtotal gastrectomy in which 80-90 per cent of the distal stomach is removed. These patients may develop postprandial abdominal fullness, excessive weight loss, anemia due to iron deficiency and various nutritional deficits. Medical treatment consists of frequent small feedings, antispasmodics and replacement of iron and vitamins. For those patients who fail to improve on this therapy, remedial operation to enlarge the gastric reservoir may be necessary. The operative procedure that we have found most beneficial is the double limb jejunal pouch described by Poth. Each segment of jejunum is from 10 to 15 cm long. The isoperistaltic segment is joined to the gastric remnant, and the antiperistaltic segment is anastomosed to the duodenum. The two segments are then converted into a single receptacle. It is important to add vagotomy if this has not been done at the original operation, otherwise ulceration may develop in the jejunal pouch.

In 12 patients with small gastric pouch syndrome corrected by a Poth double limb jejunal pouch interposed between the gastric remnant and duodenum, the results have been excellent in 4, good in 3, fair in 3, and poor in 2. Analysis of the unsatisfactory results revealed that ulceration occurred in 2 because of failure to do a vagotomy at the time the pouch was constructed. In patients with less than an 80 per cent resection, dilatation and sacculation have occurred in the jejunal pouch over a period of 3 to 8 years resulting in stasis and inadequate gastric emptying. When limited to patients with very high (greater than 80 per cent) resection, these pouches have provided effective relief but should not be used as remedial operative procedures in patients who have had standard two-thirds to three-fourth gastrectomies.

The etiology of postvagotomy diarrhea is unknown. Dragstedt has suggested that it results from gastric stasis and hypoacidity producing excessive fermentation and increased bacterial content in the small intestine. Altered pancreatic and biliary function after truncal vagotomy has been postulated as a cause. Changes in the gastrointestinal mucosa with atrophy of mucosal villi and decreased blood supply are possible etiological factors. While various theories based on extensive experimental and clinical data have been proposed, the exact cause is still not known.

While diarrhea may be a component of the dumping syndrome, some patients have diarrhea unassociated with dumping. These patients may have from 10 to 25 copious watery stools in a 24 hour period. Their diarrhea is generally explosive in onset and may occur without warning. Frequently, they cannot distinguish the urge to pass flatus from a bowel movement and may have fecal incontinence. Symptoms may be so pronounced that excessive weight loss and malnutrition incapacitate the patient economically and socially. Conservative treatment consisting of strict dietary regimen, antispasmodics, opi-

ates, diphenoxylate hydrochloride and antibacterial drugs may be of no avail.

For control of this severe, intractable postvagotomy diarrhea in 9 patients, a 10 cm jejunal segment about 100 cm distal to Treitz's ligament has been reversed to an antiperistaltic position. All have benefitted with stool frequency reduced from 10 to 25 watery movements per day to one to three formed stools daily. Weight loss and nutritional deficiencies have been corrected as well as anemia. Intestinal transit time has been markedly slowed without evidence of obstruction.

In four patients who had severe vasomotor symptoms of dumping and disabling postvagotomy diarrhea unrelated to dumping, a double jejunal reversed segment has been utilized. A 10 cm reversed segment has been interposed between the gastric pouch and the duodenum and a second reversed segment inserted 100 cm distal to Treitz's ligament. In all 4 patients both the dumping syndrome and postvagotomy diarrhea have been alleviated.[6]

SUMMARY

By taking an accurate history from the patient, it is usually possible to delineate the various entities that comprise the postgastrectomy syndrome.

The most common postgastrectomy complaint is early postprandial dumping. The majority of these patients can be improved by dietary measures which limit their carbohydrate intake and restrict fluids with meals. There are a very few patients who have such severe symptoms that they are severely incapacitated and remedial surgery may be indicated. The interposition of a single 10 cm antiperistaltic jejunal segment between the gastric pouch and the duodenum has proven to be an effective procedure for these patients.

Afferent loop obstruction is a mechanical problem which requires surgical relief. It may be prevented or alleviated by avoiding a gastrojejunostomy (Billroth II) type of anastomosis.

Reflux gastritis is being recognized with increasing frequency. Both the isoperistaltic jejunal segment (Henley loop) and the Roux-en-Y diversion have been effective as remedial operations for reflux gastritis and merit greater awareness by gastroenterologists and surgeons. The Roux-en-Y is preferred as a remedial operation for reflux gastritis because of its technical simplicity and lower morbidity rate.

The small gastric pouch syndrome occurs in patients who have had high (80 per cent) subtotal gastrectomy. In symptomatic patients a double limb jejunal pouch interposed between the gastric remnant and duodenum may provide relief.

Postvagotomy diarrhea unrelated to dumping is a rare disorder which may be corrected by reversing a 10 cm jejunal segment approximately 100 cm distal to Treitz's ligament. In four patients who had both severe postprandial dumping and postvagotomy diarrhea, double reversed jejunal segments have been utilized with success. ★★★

Nashville General Hospital (37210)

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Seminar in Neuropathology: Part II

J. BEBIN, M.D., Ph.D.
Jackson, Mississippi

As noted in Part I of the seminar (published in the June 1974 issue of the Journal MSMA), the purpose is to present and discuss certain of the most interesting diagnostic problems in brain tumors encountered in daily practice. In this issue are Cases 3 and 4; Nos. 5 and 6 will appear in the August issue.

RETICULUM CELL SARCOMA—MICROGLIOMA

Case No. 3: A 48-year-old man was referred to the neurosurgery clinic because of increasing headaches and somnolence. He was an asthmatic with chronic renal disease. On admission he complained of severe, diffuse headaches and somnolence. Physical examination revealed a right hemiparesis associated with dysphasia. Echoencephalography was negative. The EEG showed a dysrhythmia of slow waves in the frontotemporal region bilaterally. The funduscopic exam was normal. He was admitted to neurosurgery on Aug. 28 with a temperature of 36.6° C, pulse 90 per minute, and blood pressure 140/70. Laboratory data were within normal limits. X-rays of skull and lungs were normal. In angiographic studies, the left internal carotid arteriogram revealed an increased number of vessels in the lenticulostriate arteries interpreted as an A-V anomaly in the left basal ganglia region. The right internal carotid and vertebral arteriograms were normal. The course was one of progressive deterioration with increased right hemiparesis, lethargy and episodes of confusion and agitation. The patient refused to eat, became progressively weak and lost considerable weight. He expired one and a half months after admission.

The brain weighed 1400 grams. It appeared edematous and congested. Multiple sections revealed edema and congestion throughout. The left basal ganglia, thalamus and adjacent white matter were infiltrated by a soft, grayish, ill demarcated neoplasm. This also extended into the internal capsule and corpus callosum and, through this commissure, into the white matter of the opposite temporo-occipital region. The ventricular system was compressed and displaced toward the right. The brainstem, cerebellum and medulla exhibited moderate congestion and edema. The spinal cord was not examined. Multiple sections of the neoplasm were stained by the following methods: H & E, Kluver, reticulin, and Hortega's silver carbonate for microglia. With slight variation, the appearance of the tumor on these sections was similar to the slide submitted for the seminar (see Figure 4). It consisted of a densely cellular neoplasm composed of small round cells with dense nuclear chromatin and scant cytoplasm, identifiable as lymphocytes, mixed with larger cells with indented nuclei and prominent nucleoli, reticular cells. A certain number of cells resembling plasma cells and binucleated elements was also present. Mitoses were numerous throughout. The central portion of the tumor was densely cellular with the cellular elements arranged perivascularly and filling the distended Virchow-Robin spaces. At the periphery, the cellularity decreased and tumor cells infiltrated the surrounding parenchyma. Lymphocytes were abundant around the blood vessels and cells with notched, deeply staining nuclei and the appearance of microglia, were also present. Hortega's silver carbonate stained confirmed this suspicion. The reticulin stain revealed an increase of perivascular reticulin fibers extending in a lacy pattern throughout the neoplasm, a feature of great significance in the diagnosis of this type of tumor. A reactive astrocytosis was present at the periphery of the tumor where it infiltrated the relatively tumor-free brain parenchyma.

Presented at the Tri-State (Ala.-La.-Miss.) Pathology Meeting, Jan. 29, 1974, Biloxi, Miss.
From the Department of Pathology, University of Mississippi School of Medicine, Jackson, Miss.

Reticulum cell sarcoma—Microglioma is one of the more controversial neoplasms because there is no agreement among neuropathologists as to the cell origin. Bailey (1929) described such tumors under the term perithelial small cell sarcomas, and later Yuile (1938), and Kinney and Adams (1943) called them primary reticulum or histiocytic sarcomas of the brain. The resemblance of many of the cells to microglia was noted, but they were of the opinion that the term "reticulum cell sarcoma" was preferable since one could not decide whether the tumor cells arose from meningeal histiocytes or from microglia. Russell et al (1948) criticized this opinion and argued in favor of the term microglioma.

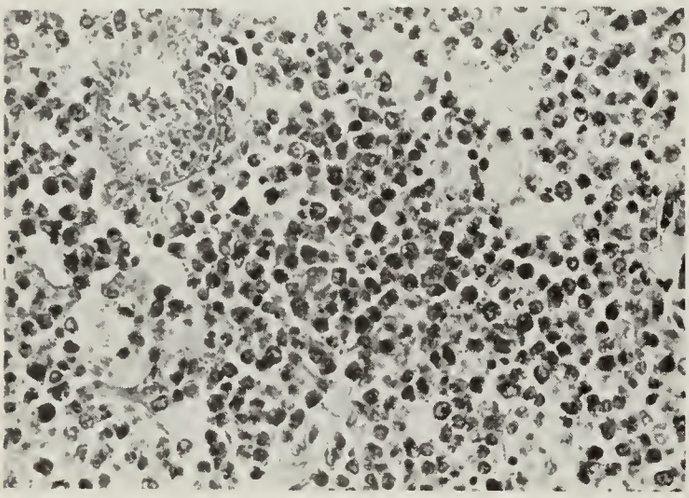


Figure 4. Case No. 3: This photograph shows the pleomorphic and dense cellularity of the neoplasm composed of malignant cells of the reticuloendothelial system mixed with small cellular elements, mostly lymphocytes. H & E × 400.

Theoretically, neoplasms of the reticuloendothelial system within the brain may be derived from microglia or primitive reticulum cells (histiocytes) or both. Reticulum cells and microglia are difficult to distinguish cytologically in routine stains. The differences can be appreciated only with the use of specific silver impregnation methods. This method, according to Marshall, permits distinction between two types of reticuloendothelial cells: (1) a mature, argyrophilic type; microglia; and (2) an immature, non-argyrophilic; reticuloendothelial cell, from which microglia originates. Russell and associates thought that the more primitive cell elements in these tumors arose from dedifferentiation of mature forms (microglia), and the alternative possibility exists, that these tumors may originate from the more primitive elements (reticuloendothelial cells). Burnstein, Kernohan and Uihlein (1963) reviewed a large number of these neoplasms and classified them as reticuloendothelial cell sarcomas. More recently Schaumburg and Adams (1972) supported the interpretation of these neoplasms as malignant lymphomas. They agree with most pathologists that such tumors should be grouped with malignant reticulocytosis. A recent electron microscopic study has shown the cells of the primary nervous system tumor of this type to be similar to the cells of the lymph-node visceral tumor (Horvat et al, 1969).

Tumors of the lymphoreticular system could be *primary* and involve solely or principally the CNS, or *secondary*, where the involvement of CNS or meninges is associated with systemic (visceral) disease (Rubinstein, 1972). The reticulum cell sarcoma-microgliomas are rapidly growing neoplasms. In some cases there is a long history of insidious proliferation of visceral lymphoreticular elements upon which an intracranial tumor supervenes.

Its incidence is not known. Burnstein et al found 41 cases of reticuloendothelial sarcoma among 240 cases of primary sarcoma of the brain, and Shaumburg and associates found 121 cases of systemic RCS and 23 cases of primary RCS of the brain among 25.200 autopsies (1940-1970). All ages are affected with maximal incidence in the fifth and sixth decades. There is a 2:1 male predominance. The cerebral hemispheres are most frequently involved (temporo-occipital region) followed by the cerebellum and brain stem. Multicentricity is frequent and, rarely, the neoplasm is restricted to the leptomeninges. The gross and microscopic features correspond very well with those in the present case. It should be remembered that stains for reticulin and Hortega's silver carbonate for microglia are very helpful but not always diagnostic.

The microscopic picture is usually characteristic. The distinction between a reticulum cell sarcoma and a polymorphic cell sarcoma is often impossible. These tumors tend to be multifocal, have a rapid growth and a fatal course. They are, however, responsive to treatment with radiotherapy. Schaumburg et al report dramatic improvement after radiation and survival time of three to five years.

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SUBEPENDYMAL GIANT-CELL ASTROCYTOMA ASSOCIATED WITH TUBEROUS SCLEROSIS

Case No. 4: A 6-year-old girl was admitted Aug. 25 and died 24 hours later. She had suffered from headaches assoeiated with periodic vomiting for two months, but otherwise was in apparent good health.

The day before admission to the hospital she eomplained of intense headaehe whieh was aeeompanied by vomiting and followed by progressive lethargy and eonvulsions.

Examination on admission revealed a slight anisocoria, the right pupil being larger than the left, hypertonicity in lower extremities, and "erisis" of decerebration. She was transferred eomatose to the neurosurgical service, with dilated, fixed pupils and deeerebrate posturing. Her temperature was 40° C.; respiration was regular; and there was bilateral papilledema. She remained eomatose with decerebrate "crisis." A ventriculogram via-pereutanea was performed and revealed a dilated right lateral ventricle with displaeement of the septum to the left. These findings were interpreted as resulting from an "expanding lesion" in the right hemisphere.

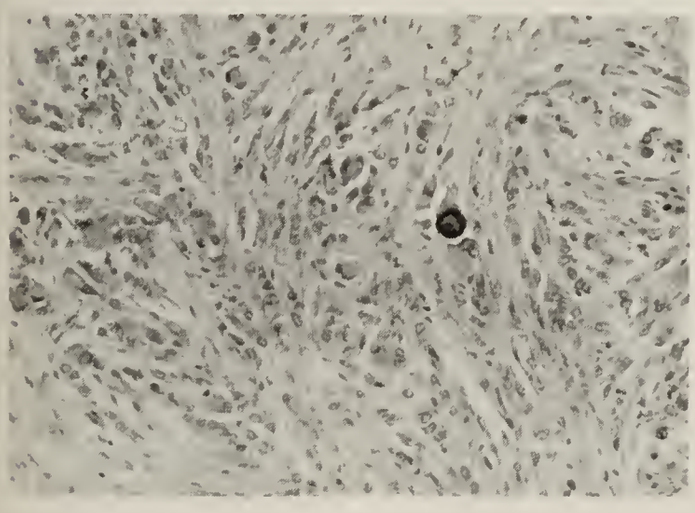


Figure 5. Case No. 4: Giant and elongated astrocytes form a streaming pattern. H & E × 200.

The child was treated with manitol and eortisone without any ehange in status and expired 24 hours after admission.

At post-mortem examination, the brain weighed 1520 grams. It appeared swollen and inspection of the external surface revealed typical tubers among

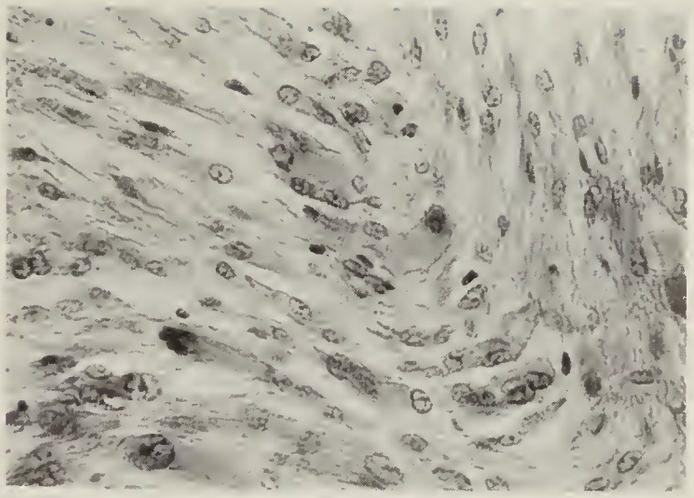


Figure 6. Case No. 4: Higher magnification showing larger and strap-like tumor cells. H & E × 400.

the cerebral eonvolutions. These appeared firm, enlarged and well eircumseribed eonvolutions; some with smooth surfaees, others slightly indented in their central portions, placed indiseriminately among normal eonvolutions. The blood vessels and the meninges were normal. The brain was sectioned eoronally and revealed many "tubers," a variable thiekness of the eerebral cortex in several regions, sometimes deepening into the white matter. The ventrieular system was dilated and asymmetrie; the right lateral ventriele more than the left. In the left cerebral hemisphere, near the interventrieular foramen, there was a nodular mass 2.5 em in diameter with a hemorrhagic eenter, protruding from the floor of the lateral ventriele. This mass eompletely obliterated the left interventrieular foramen. A smaller nodule 0.5 em in diameter was present in the floor of the frontal horn of the ventriele. The brain stem was edematous. The eerebellum showed edema and irregularity of its foliae.

Briefly, tuberous selerosis is a dysgenesia assoeiated with tumor formation. These eonditions are based upon some maldevelopment in embryonie or fetal life. In some eases the tumors are present at birth. Its congenital nature is undisputed. In others, post-natal evolution leads to symptoms in adolescenee or adult life. The principal neuropathologie features of tuberous selerosis are: *convolutional foci of sclerosis* in whieh the gliosis is assoeiated with gross disturbances of eell arehitecture and with abnormal eell forms of neurons and astroeytes, some of giant size. The ependyma of the lateral ventricle may be replaeed by foei of subependymal tissue growths, "eandle gutterings," composed of giant astrocytes and elongated piloeytie cells suggestive of polar spongioblasts. *Foci of glial proliferation* and

heterotopias may be present in parts of the brain which appear grossly normal.

The neoplasm in the present case is a subependymal giant cell astrocytoma characteristically associated with tuberous sclerosis. On gross inspection it appeared as a sharply defined mass with a soft homogeneous grayish surface and hemorrhagic center. Foci of calcification, a common feature of this tumor, were present. Microscopically (see Figures 5 and 6), this tumor consists of numerous giant and irregular elements resembling gemistocytic astrocytes and others with irregular shape and strap-like appearance. These elements are arranged in streams and whorls of cells, or in highly compact groups without definite architecture. In some areas perivascular pseudorosettes are formed. The cell cytoplasm is eosinophilic and homogeneous and the nuclei, often eccentric, may contain prominent nucleoli giving them a resemblance to ganglion cells. The tumor contains abundant blood vessles of varying size but there is no endothelial proliferation. Mitoses were infrequently seen.

These tumors are slowly growing neoplasms, and produce obstruction of CSF circulation. Malignant changes such as increased cellular density, anaplasia, and abnormal mitoses are exceptional.

These tumors are rare in tuberous sclerosis. Chritchley and Earl (1932) found one such lesion among 29 patients. Its exact frequency is unknown. True neoplasms have often been confused with the common non-neoplastic subependymal nodules.

The disease is often familial and characterized by a triad of: (1) adenoma sebaceum of face; (2) benign tumors of the heart and kidneys; and (3) central changes in the brain (already described). Incomplete or "forme frustres" occur frequently among relatives. These forms may exhibit epilepsy or mental deficiency only, or adenoma sebaceum, or visceral and retinal tumor alone.

The brain tumors associated with tuberous sclerosis usually have been designated as astrocytomas or spongioblastomas by Jervis (1954). According to Russell and Rubinstein they are a distinctive form of *benign giant-cell astrocytoma*. The interpretation of these gliomas is controversial. Most authors favor the view that they are a variety of astrocytoma and they should be separated from the more malignant form of giant-cell astrocytomas and ganglion cell tumors. They probably originate from the nests of monster astrocytic cells which are characteristically present in the cerebellum of patients with tuberous sclerosis. ★★★

2500 North State Street (39216)

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It does look like most of the trouble men get into these days comes through their mouths—either eating, drinking, or talking.

Radiologic Seminar CXXXXI: Volvulus of the Sigmoid Colon

WALTER T. COLBERT, M.D.
Natchez, Mississippi

OBSTRUCTION of the large bowel is usually caused by carcinoma of the distal portion of the colon, or by diverticulitis of the sigmoid colon and its complications. A less common cause of colon obstruction is volvulus of the sigmoid colon.

Sigmoid volvulus presents as a more acute problem than the usual colon obstruction caused by neoplasm or inflammatory disease. Volvulus is seen primarily among elderly persons and occurs most often in patients who have long standing constipation and poor bowel habits. The acute attack is characterized by acute and marked abdominal distention, failure to pass either gas or stool, and acute lower abdominal pain.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Jefferson Davis Memorial Hospital, Natchez, Miss.

CASE REPORT

This 83-year-old male patient with advanced cerebral arteriosclerosis was admitted to the hospital with a history of vomiting, diarrhea, and obvious abdominal distention as noted by his family. On physical examination, the prominent findings were limited to his abdomen. There was considerable distention



Figures 1 and 2. The plain films of the abdomen are usually diagnostic. The flat film (Figure 1) and the erect film (Figure 2) (see next page) demonstrate the classical "inverted U" appearance of the distended sigmoid colon. Additional distention can be noted in the remainder of the colon.

and the abdomen was tympanitic. There was tenderness over the entire abdomen, but no masses or organs were palpable. The rectal examination demonstrated some prostatic enlargement. Flat and erect films of the abdomen (see figures 1 and 2) demonstrated the typical appearance of colon obstruction secondary to volvulus of the sigmoid. The massive distention of the sigmoid colon, with fluid level formation on the upright film, is typical of this type of colon obstruction. The abdominal film made following introduction of barium into the distal colon demonstrates the actual site of torsion. This patient had prompt surgery for detorsion of the volvulus, and subsequently made an uneventful recovery.

SUMMARY

A case of sigmoid volvulus of considerable magnitude is presented. The plain film findings are diagnostic, and the barium enema examination is confirmatory. Prompt surgery was required for relief. Occasionally, detorsion can be accomplished by barium enema examination in lesser degrees of sigmoid volvulus. ★★★

P.O. Box 1488 (39120)

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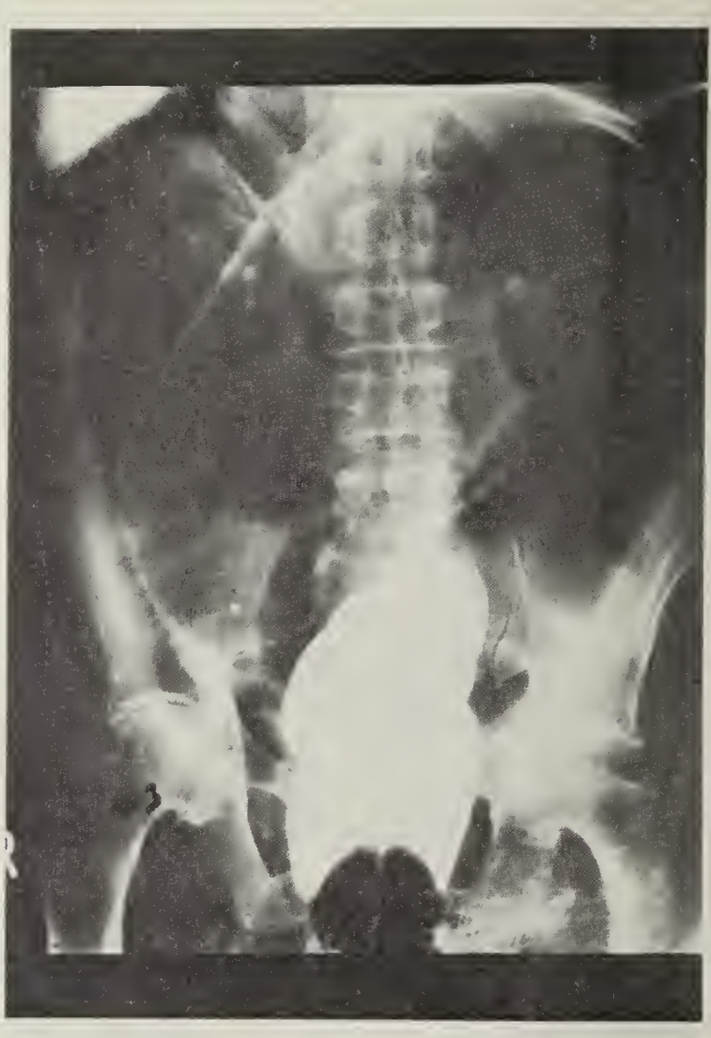


Figure 3. Barium Enema Film. The actual site of torsion of the sigmoid colon is demonstrated on the contrast study. Again the "inverted U" appearance of the sigmoid colon is depicted.

RIDDLE

Q: What is white and goes quack, quack?
A: A disillusioned nurse.
—*The Nebraska Medical Journal*

Mississippi Physicians' Attitudes Toward The Supreme Court Abortion Decision

PAUL T. MURRAY, Ph.D., and HERMAN JEW, B.A.
Jackson, Mississippi

A sample of Mississippi physicians was surveyed to determine their attitudes toward the Supreme Court abortion decision and their attitudes toward abortion in general. The responding doctors expressed overwhelming support for abortion in the first trimester in cases of rape, incest, danger to the health of the woman, and probable deformity of the fetus. Considerably less approval was recorded for abortion in cases of five "non-traditional" justifications. Nearly all in the sample felt that abortions should be performed in hospitals and only MDs should be allowed to perform them. A slight majority approved of the Supreme Court decision, but most were in favor of no governmental regulation of abortion. Psychiatrists in the sample showed consistently more liberal attitudes toward abortion than obstetricians and gynecologists with physicians in general practice and other specialties being most conservative.

On Jan. 22, 1973, the U. S. Supreme Court handed down a decision which was to have far reaching consequences for the American medical profession. In the case of *Roe vs. Wade,* the court's ruling sharply restricted the states' prerogatives to regulate abortions. The decision clearly stated that pregnancies could legally be terminated even if the life of the mother were not endangered, thus overturning existing abortion statutes in 46 of the 50 states. The court's findings were summarized in three major provisions:[1]

1. In the first trimester of pregnancy the decision to perform an abortion must be left to the woman's attending physician and cannot be regulated by the state.

2. During the second trimester of pregnancy the state may, if it wishes, regulate abortions in ways which are "reasonably related to maternal health."

3. In the last 10 weeks of pregnancy, when the fetus is considered viable, the state may regulate or forbid abortions, except where necessary to preserve the life or health of the mother.

With this ruling, the justices affirmed the argument that the decision to terminate a pregnancy, at least during the first trimester, must be left to the woman and her physician without any interference from the state.

Public reaction to the decision followed swiftly. Hailed by family planning and women's liberation organizations, the Court was denounced by religious and political leaders. Catholic bishops described the ruling as "shocking," "horrifying," "abominable," and as "an unspeakable tragedy." In subsequent weeks national "Right to Life" organizations formed to combat the trend toward more liberal abortion laws. Constitutional amendments to reverse the court decision and restore the former standards were introduced in Congress.

What was the reaction of physicians in the midst of this controversy? As the professional group most directly involved in the ethical and legal questions surrounding abortion, their attitudes are of crucial significance. Preliminary evidence indicates that physicians would probably be more receptive to changes in the abortion statutes than the general public. Both the American Public Health Association and the American Medical Association had called for reforms in existing abortion laws. Meeting in June

From the Department of Sociology and Anthropology, Millsaps College, and the Jackson Planning Commission, Jackson, Miss.

1970, the AMA House of Delegates approved a resolution which recommended termination of pregnancy when in the best interest of the patient and when warranted by the standards of sound clinical judgment.[2] Because of physician support for this position, we predicted that they generally would react favorably to the court decision.

To test this hypothesis and to explore the attitudes of physicians on the subject of abortion in general, we designed a questionnaire and selected a sample of active, licensed doctors in the state of Mississippi. In March 1973, approximately three months after the Supreme Court decision, a confidential, closed-response questionnaire was sent to all psychiatrists in the state (56), one-half of the obstetricians and gynecologists (59), and one-tenth of the remaining physicians (139). The names were selected from the directory of the Mississippi State Medical Association. Of the 234 questionnaires mailed out, 103 usable replies were received—24 from psychiatrists, 30 from obstetricians and gynecologists, and 49 from other physicians.

The doctors who responded to our questionnaire were a remarkably homogeneous group. Most were white (98 per cent), male (96 per cent), and Protestant (87 per cent). More than half (55 per cent) were native Mississippians and another 26 per cent were born in other Southern states. The median age for the group was 45 years and one-third (35 per cent) were residents of Jackson.

The members of our sample were first asked to indicate their agreement or disagreement with a series of statements describing conditions which could justify abortion. Four conditions were grouped together as "traditional" justifications for abortion: danger to the life of the woman, rape, incest, and probable deformity of the fetus. As shown in Table I, the physicians were virtually unanimous (98 per cent) in their opinion that abortion is justified to save the life of the woman during the first trimester of pregnancy. Similar overwhelming agreement was found in support of abortion during the first trimester in the case of rape (94 per cent), incest (93 per cent), and probable deformity (87 per cent).

The respondents were next asked to indicate their agreement or disagreement with five statements describing "non-traditional" justifications for abortion in the first trimester. Predictably, there was considerably less support for these statements than for the traditional justifications. As shown in Table II, three-fourths of the physicians (73 per cent) approved of abortion if the emotional well-being of the mother were endangered. Two-thirds (63 per cent) agreed that abortions should be allowed if the pregnant woman was under 16 years old. Approximately half (51 per cent) approved of abortion in the case of illegitimacy. Thirty-nine per cent endorsed abortion if the child would be placed on welfare and 38 per cent would allow abortions if the birth of a child would place a financial strain on the parents.

TABLE I

TRADITIONAL JUSTIFICATIONS FOR ABORTION, FIRST TRIMESTER (PER CENT AGREEING)

	Total	*Psych.*	*Ob-Gyn*	*Other MDs*
Danger to woman's life	97	96	97	98
Rape	93	100	93	90
Incest	93	96	90	92
Deformity	89	96	90	85

TABLE II

NON-TRADITIONAL JUSTIFICATIONS FOR ABORTION, FIRST TRIMESTER (PER CENT AGREEING)

	Total	*Psych.*	*Ob-Gyn*	*Other MDs*
Emotional well being endangered	73	92	78	61
Under 16	63	67	73	55
Illegitimacy	51	55	53	49
Child placed on welfare	39	35	37	45
Financial strain on parents	38	42	43	31

The doctors in the sample revealed considerable disagreement when asked who should be allowed to make the decision to terminate a pregnancy during the first trimester. Seventy-one per cent felt that both the pregnant woman and her physician should make the decision, but 55 per cent also agreed that the woman alone should be the one to decide. Fifty-seven per cent indicated that abortions should be performed with the consent of the woman's husband and 54 per cent would require parental consent for abortions performed on unmarried women under the age of 18. These responses are presented in Table III.

When asked where abortions should be performed and who should be allowed to perform them, the doctors in the sample again demonstrated considerable agreement. As shown in Table IV, 87 per cent of the physicians felt that abortions during the first trimester of pregnancy should be performed in the hospital, while 64 per cent felt they could be per-

formed in special clinics, and only 34 per cent would recommend that they be performed in the physician's office. All but three of the doctors responding (97 per cent) agreed that physicians should be the only ones allowed to perform abortions.

After determining their attitudes toward abortion in general, we asked the physicians in the sample for their opinions regarding the Supreme Court decision on abortion. An overwhelming majority of the doctors polled felt that the government should not attempt to regulate abortions. This sentiment remained strong regardless of whether the abortion would be performed in the first (91 per cent), second (88 per cent), or third (84 per cent) trimester of pregnancy. Apparently, our respondents are of the opinion that the termination of pregnancy is primarily a medical decision rather than a legal question. A narrow majority (54 per cent) of the physicians agreed that abortions should be allowed according to the guidelines laid down by the Supreme Court and by about the same margin (57 per cent) they felt that Mississippi should change its laws to comply with the ruling. These data are presented in Table V. In view of their negative attitudes toward government regulation of abortion, however, it is difficult to determine whether those doctors in disagreement with these items felt that the abortion statutes should not have been altered or all legal restrictions should be removed.

The physicians in this sample were also questioned regarding their opinions on the traditional and non-traditional justifications for abortion during the second and third trimesters. As expected, there was less support for abortions performed during the later stages of pregnancy. However, more than half of the doctors still approved of abortion for each of the "traditional" reasons, even during the third trimester. There was considerably less support for abortions performed for the five "non-traditional" reasons. Fewer than one-fourth of the respondents, for example, agreed that abortions should be performed during the third trimester if the woman's emotional well-being were endangered. Although this pattern of lessened support for abortion during the later stages of pregnancy is clear cut and unmistakable, we did not pursue this analysis further because the high rate of non-response to these questions (25 per cent) would have endangered the validity of our findings.

An interesting, though not completely consistent pattern, emerged when we compared the responses according to the physicians' area of medical specialization. In general, the psychiatrists tended to be more liberal on all questions relating to abortion, with the obstetricians and gynecologists being somewhat less liberal, and the physicians in other fields being most conservative. These differences are not large, but are repeated with sufficient regularity to establish a definite pattern. On three of the four "traditional" justifications for abortion the psychiatrists were most likely to approve of abortion. They were also more likely than other doctors to approve of abortions for three of the five "non-traditional" reasons. As might be expected, they are substantially more favorable toward abortion in cases where the emotional well-being of the mother is endangered. Psychiatrists are less likely to approve of abortion, however, if the child would be placed on welfare. They feel much more strongly than other physicians that the decision to terminate pregnancy should be

TABLE III

PERSONS INVOLVED IN ABORTION DECISION, FIRST TRIMESTER (PER CENT AGREEING)

	Total	*Psych.*	*Ob-Gyn*	*Other MDs*
Woman and physician	71	88	69	63
Woman alone	55	74	55	47
Husband's consent	57	38	57	63
Parental consent	54	42	57	59

TABLE IV

LOCATION OF ABORTION AND WHO SHOULD PERFORM, FIRST TRIMESTER (PER CENT AGREEING)

	Total	*Psych.*	*Ob-Gyn*	*Other MDs*
Hospital	87	86	83	90
Clinic	64	57	52	76
Doctor's office	34	53	19	34
MD only perform	97	100	93	98

TABLE V

ATTITUDES TOWARD SUPREME COURT DECISION (PER CENT)

	Total	*Psych.*	*Ob-Gyn*	*Other MDs*
No government regulation first trimester	91	96	90	89
No government regulation second trimester	88	90	84	89
No government regulation third trimester	84	81	80	89
Abortion allowed according to Supreme Court	54	58	62	48
Change law to comply with Court decision	57	63	62	51

made by the woman alone and are less likely to seek consent of parents or husbands. These findings raise the question of why this difference should appear. Is it attributable to the self-selection process for psychiatric specialization or the psychiatric training itself? Could this liberalism be traced to other factors such as age or region of origin? Unfortunately, our sample is not large enough to satisfactorily resolve these questions.

In conclusion, we can state unequivocally that a large majority of Mississippi physicians approve of abortion for a variety of medical and non-medical reasons. They are more likely to endorse abortion during the first trimester of pregnancy than during the second or third trimesters. Most of the doctors surveyed feel that the government should not regulate abortion, rather the decision should be left up to the woman and her physician. Most Mississippi doctors approved of the Supreme Court decision removing legal restrictions on abortions during the first trimester of pregnancy, though some may feel that the court did not go far enough. In this regard, the position of the medical profession is at odds with the stand of many prominent religious leaders and a large segment of public opinion (though not the majority). Thus far, the Supreme Court has borne most of the animosity of the "right to life" forces, but the potential for conflict with the medical profession exists, particularly if the former restrictions on abortion are ever reimposed. ★★★

Millsaps College (39210)

REFERENCES

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You'll notice that most of the people favoring birth control are those who have already been born.

Address of the President

ARTHUR A. DERRICK, JR., M.D.
Durant, Mississippi

TWO YEARS AGO this House of Delegates elected me as president-elect and one year ago I was installed as your president. This is one of the greatest honors that can be conferred upon a physician. An honor —yes! But you also gave me a job to do. A job to represent the medical profession and to emphasize that our profession is one of service. A truly great profession! I now return to you with some thoughts and reflections on what I have seen and heard.

During the past two years I have attempted to visit with every physician possible at every medical meeting I have attended. Each meeting has been a pleasant and rewarding experience. Of all the invitations I received from our component medical societies—a total of 16—I am happy to report there was only one I could not accept because of a prior commitment.

One of the most gratifying experiences I have had during the past year has been the opportunity to visit with the medical students at our University of Mississippi School of Medicine. I have also had the privilege of participating in programs with lay organizations in many fields of endeavor and I have visited personally with many people in government. This has been done with the primary purpose of attempting to attain the goals expressed by this House of Delegates. But not only have I conveyed our goals —I have listened.

I have found that there is much at issue both within and without our profession as to the merits of our endeavors. We are not alone, however, because issues abound in our land today around most of the professions.

I believe that there is one key word that illustrates the problem and offers a future course of action for our profession. That word is "responsiveness." It is my belief that we must strengthen our ability to respond—to respond to the health service needs and desires of the American people. Now this is not to say that we have been unresponsive. It is to say that we must better convey to the public what is right and wrong about health care.

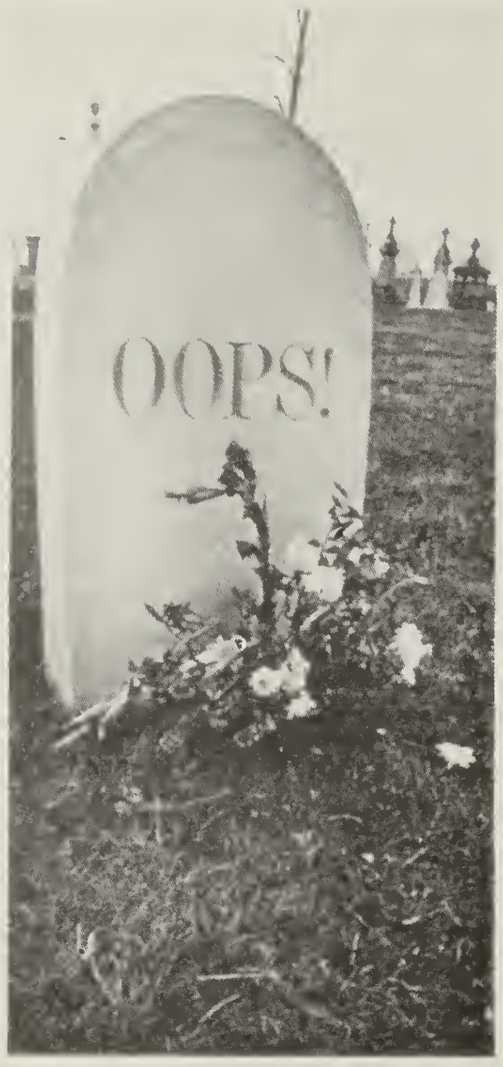
Before we are in position to inform the public, however, we must be informed ourselves. Our national, state, and local professional societies furnish the vehicle for an informed profession. I have found that there is effective communication on health matters between the national and state levels. Unfortunately, however, on the local level I have found, with few exceptions, a breakdown in communication and a lack of participation.

I believe that we must develop a more informed and missionary zeal on behalf of our profession at the grass roots level. We must have better attendance at component society meetings. We must have more face to face communication between those in positions of responsibility in our state medical association and the membership. I am not talking about the staff here. I mean practicing physicians representing other practicing physicians on behalf of organized medicine.

This will take time and effort. Time away from practice and effort to fully understand the many issues facing our profession today. Those called upon to serve should be fairly compensated. There should be no barriers to service. I recommend that this House of Delegates direct a committee of the House to study this matter and report back to the 1975 Annual Session. I further recommend deletion of that part of Section 3, Article VI, of our MSMA By-Laws, that requires nominees for office to have attended two of the last three annual sessions. Experience has shown that this requirement has been a definite barrier to service in this association.

We, individually and collectively as a profession, must be willing to examine both the positive and negative aspects of health care today. Hopefully spending most of our time on improving the latter. I speak now of three areas—access, quality, and cost.

President, Mississippi State Medical Association, 1973-1974. Read before the House of Delegates, 106th Annual Session, Biloxi, May 6, 1974.



It always happens so fast.

And, this time, you're right. It did happen to "the other guy."

You know: The guy who wouldn't hurt a fly, turn down a friendly drink—or take a cab home instead of driving. A nice guy who'd now and then smoke in bed, maybe swim out a little too far, sometimes hurry a little down the stairs.

We know you knew him. And that you'll miss him.

We just don't want you to join him.

"Oops" is a pitiful epitaph.

National Safety Council

If you don't like thinking about safety, think where you'd be without it.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**

Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renat function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules, syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE PHARMACEUTICALS
CRANBURY, NEW JERSEY 08512

On this matter of access, it takes no great research to conclude that we have a problem in Mississippi. We have one-half the national average of physicians per 100,000 population and our supply of other health professionals is comparable. Of even more significance, we have a dire shortage of physicians in the primary care specialties of pediatrics, internal medicine, and family practice. This at a time when medical schools in the United States are graduating more physicians than ever—and there is talk of a doctor saturation by 1980.

So what is wrong in Mississippi? Medicine functions in the free enterprise, competitive system of the American economy. We have not been competitive. We are losing our medical school graduates. We are failing to compete with other areas of the country for health professionals.

But this is only one side of the coin. The other side is where have we committed our public resources? What priority does health care have in public funding and support? Where does it stand with the body politic?

LEGISLATIVE PRIORITIES

During this last session of the Mississippi Legislature while several million dollars were being authorized for another football stadium, our medical school was accepting only 15 per cent of its applicants. Fire ant control was being strengthened by some additional several millions while the Medicaid Program was being funded at the 1969 rate for physician services. That rate is some 50 per cent of current professional fees.

As an Ole Miss Rebel and a small-town resident, I can appreciate the need for both football stadiums and fire ant control. But I must ask where on a scale of priorities do these two items rest. Are we to have more football stadiums and fire ant control at the expense of less health services? The answer is yes—unless we act to better express the concerns of our profession to our elected representatives. I would urge you to consider carefully the recommendation of the Council on Legislation before you at this meeting concerning our commitment to better health care representation in state government.

In the not too distant past, the state senator or representative would seek his physician's views on legislative health matters. Some still do. But the great majority do not and we must now contact our senator and representative and convey our views.

The best time to talk to an elected official is when he's running for office. The best way to talk to him is through a local candidate support committee composed of physicians, their families and their friends. By such support we can assure that there will be an open channel of communication between medicine and government.

The candidate support committee's role is to provide visible and solid support on the part of the medical profession in the electoral district of the candidate. This support takes the form of financial and voter support from the healing arts professions.

Local candidate support committees can be legally created under our Mississippi Medical Political Action Committee (MPAC). The PAC can serve as a vehicle to furnish necessary organizational support.

HELP VOTING INDEX

I hope that we see local candidate support committees organized throughout the state during next year's legislative elections. If you don't know where to start, may I suggest you consult the association's health voting index for your legislator.

Moving now to the areas of quality and cost of health care services, I wish to begin with a fact of life. The American people want to prepay their health care costs and receive quality medical services when needed. Consider that in 1973 some 65 per cent of personal health care expenditures were paid by third parties compared to 45 per cent in 1965.

We must accentuate the positive of quality and cost of health services financed through commercial and Blue Shield plans. If we do not, the American people are going to seek solutions from government which will be less satisfactory to all concerned.

ACCOUNTABILITY

I urge that we demonstrate and document our accountability with respect to cost and quality of health services. I speak here of peer review that leaves no doubt that we are interested in this area of public concern.

Now much has already been said about PSRO. To judge from our House of Delegates folder this will be a lively subject before us at this meeting. (PSRO, QAP, CHAP, TAP, and other programs for medical review can always spark a discussion. Sometimes more than lively! A brief recounting may be helpful at this time.

In 1971 our association undertook to demonstrate a physician sponsored medical care review program funded by the Department of HEW. The Mississippi EMCRO Program will soon begin its fourth year of operation. Because of the foresight and work of Mississippi physicians we are in a better position to furnish leadership in peer review than most states.

Also, in 1971 the House of Delegates authorized the establishment of the Mississippi Foundation for Medical Care, the purposes of which were: (1) to establish a system for peer and utilization review; (2) to define quality care standards; (3) to establish a uniform schedule of professional services throughout the state; and (4) to serve as an intermediary between the physician and third party payor. Much work has been accomplished in each of these areas.

Last year the House of Delegates directed the foundation to proceed to implement PSRO in Mississippi under requirements of Public Law 92-603. A grant was sought and obtained from the Mississippi Regional Medical Program for this purpose. A hard working committee composed of dedicated physicians from every area of the state has labored for the past several months to arrive at a "PSRO Implementation Plan for Mississippi." This "Plan" will be presented to the annual meeting of the foundation membership to be conducted this Thursday.

I urge that we not lose sight of our long standing commitment and work in peer review. Let us not presume either that health quality and cost decisions will not be forthcoming simply because we decline to participate.

On April 30, 1974, wage/price guidelines expired for health services. I would like to commend the American Medical Association for the active role it has played in this regard. The medical profession has performed with distinction under these guidelines. Physician fees have increased at a rate far below that of the rest of the economy. I am confident that we will continue to exercise restraint and thus demonstrate our accountability with respect to the cost of medical care.

Access, quality, and cost. These are the areas where we must direct our attention. What are the problems? What solutions are we proposing? Are they responsive? We should ask ourselves what we have done—what we are doing—and what we are willing to do for our profession. The future of Mississippi medicine is in the hands of this House of Delegates. I urge you to chart a forward course. Let's be involved in the coming times! ★★★

602 North West Avenue (39063)

Age is mind over matter. If you don't mind, it doesn't matter.

Constitution and By-Laws of the Mississippi State Medical Association

CONSTITUTION

Preamble

That more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association. Among us, membership is a privilege, earned by professional qualification, personal honor, and selfless service; it is not a right vested superficially nor by statutory licensure. Truth shall be our quest; diligence, our staff; and service, our purpose.

Article I
NAME OF THE ASSOCIATION

The name and title of this Association shall be the Mississippi State Medical Association.

Article II
PURPOSE OF ORGANIZATION

The purpose of this Association shall be to federate and into one compact organization the entire medical profession of the State of Mississippi and to unite with similar associations in other states to form the American Medical Association, with a view toward the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws, to the promotion of friendly intercourse among the physicians and to guarding and fostering of their opinion in regard to the great problems of medicine, so that the profession shall become more honorable and capable within itself, and more useful to the public in the prevention and care of disease, and in the prolonging of and adding comfort to life.

The purpose of this Association shall be to promote scientific medical research and practice and it shall be a nonprofit organization.

Article III
COMPONENT SOCIETIES

Component Societies shall consist of those societies which hold charters from the Association.

Article IV
MEMBERSHIP

Section 1. Members of the Mississippi State Medical Association. Members shall be active, associate, emeritus, or honorary, according to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate and honorary shall be construed as active in connection with the rights and privileges accruing therefrom.

Section 2. Guests. Any physician not a resident of the state may become a guest during any annual session upon invitation of a member of the Association, and shall be accorded the privilege of participating in all the scientific work of that session.

Article V
SESSIONS AND MEETINGS

Section 1. The Association shall hold an annual session during which there shall be held daily not less than two general meetings, which shall be open to all registered members and guests.

Section 2. The time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix, or change, either the time or the place, or both of the annual session.

Article VI
GENERAL OFFICERS

Section 1. The general officers of this Association shall be President, Present-elect, three Vice-Presidents, one from each Supreme Court District, Secretary-Treasurer, Speaker, Vice Speaker, and Editor.

Section 2. The President, President-elect, and Vice-Presidents shall hold terms of one year. The Secretary-Treasurer, Speaker, Vice Speaker and Editor shall be elected for terms of three years.

Section 3. The officers of this Association shall be elected by the House of Delegates on the last day of the annual session following the adjournment of the general meeting, but no person shall be elected to any such office who has failed to attend two-thirds of the past two and current annual sessions and who has not been a member for the past two years.

Section 4. In addition to these general officers, there shall be an Executive Secretary who need not be a physician or member of the Association. He shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. His compensation and expenses for duties performed shall be fixed by the Board of Trustees and confirmed by the House of Delegates.

Article VII
EXECUTIVE OR CENTRAL OFFICES

The Executive Secretary shall maintain in the city of Jackson suitable offices for the discharge of his duties and for conducting the administrative affairs of the Association.

Article VIII
HOUSE OF DELEGATES

The House of Delegates shall be the legislative, business, and policy-making body of the Association and shall consist of (1) delegates selected by the component societies under authorized apportionment, (2) the general officers of the Association, (3) all past presidents, provided they still be members in good standing of the Association, (4) members of the Board of Trustees and Councils, and (5) elected committees, Delegates and Alternate Delegates to the American Medical Association, members of the State Board of Health, and members of the Board of Trustees of Mental Institutions, all of whom must be members of this Association.

Article IX
BOARD OF TRUSTEES

The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates and shall perform such duties as are prescribed by law governing directors of corporations and in the By-Laws of the Association. The Board shall consist of nine members, one from each Association District, elected for

terms of three years each. A Trustee shall not serve more than three consecutive terms.

Article X
FUNDS AND EXPENSES

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by annual dues, per capita assessments upon the membership, and by voluntary contributions. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, publications, and for any other purpose approved by the House of Delegates.

Article XI
THE SEAL

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII
AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been set officially to each component society at least two months before the session at which final action is taken.

BY-LAWS

Chapter I
MEMBERSHIP

Section 1. Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriately accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate or honorary must be legally licensed to practice medicine in Mississippi. Persons who obtained this degree prior to January 1, 1917, need not comply with this requirement but must be licensed to practice medicine in Mississippi or, if offering to practice in Mississippi must be eligible for license by reciprocity and be a member in good standing of a constituent (state) association of the American Medical Association. Membership in a component society, evidenced by the payment of dues for the current year, shall be a prerequisite to membership in the Association, except that a physician upon his initial application for membership in a component society of the Association shall be required to undergo a waiting period of ninety (90) consecutive days from the date he begins the practice of medicine in the geographical area of the component society before he may be elected to membership in the component society. No physician shall be eligible for membership who has been convicted of or who has plead guilty to either a felony or a violation of a state or federal narcotics law. The duly certified court record shall be *prima facie* evidence of pleas and convictions and cause automatic revocation of membership. No physician shall be eligible for election to or continuation of membership who does not possess a currently effective federal narcotics stamp, provided, however, that physicians in full time government service who need no registration to use, prescribe, and dispense narcotic drugs and those who, by reason of type of practice, employment, inactivity, or retirement, neither prescribe nor dispense narcotics and who for this reason alone have not applied for registration shall be exempt from this requirement.

Section 2 (a). Good Standing. Only those members in good standing shall be entitled to the rights and privileges of membership. A physician not in good standing may not be elected to office nor exercise the privilege of voting or attending any session of this Association, scientific or otherwise. The name of a physician upon the properly certified roster of a component society which has paid its annual assessment shall be *prima facie* evidence of his right to register at the annual session of the Mississippi State Medical Association. No member shall participate in any of the proceedings of the annual session until he is duly registered. No delegate or other member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section. (b) Change of State Residence. In the event that a member moves from the State, his membership shall continue until, and lapse at the end of, the current fiscal year, but this provision shall not operate to prevent a physician who moves from the state continuing his membership by payment of all dues and assessments to the state Association. (c) Obligations of Membership. When the Executive Secretary of the Mississippi State Medical Association is officially informed by the secretary of a component society that a physician is not in good standing in the component society, he shall remove the name of the physician from the rolls of the Association. A member shall hold his membership through the component society in the jurisdiction of which he practices, provided that a physician living on or near a county line may hold membership in the society most convenient for him to attend. If the society in which he chooses to secure membership does not exercise jurisdiction over the area of his residence, then permission must be obtained from the jurisdiction society to facilitate his affiliation with the extra-jurisdiction society.

Section 3. Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications: Active, emeritus, and associate. (a) Active Membership. Active members shall include all eligible members of component societies in good standing, providing that all dues and assessments in this Association as may be hereinafter prescribed have been received by the Association. (b) Emeritus Members. Any members of the Mississippi State Medical Association who has been an active member for any ten consecutive years and shall have permanently retired from the practice of medicine shall be eligible for election to emeritus membership. Election to emeritus membership for reason of retirement in the case of permanent and total disability shall merit special consideration but shall be subject to ruling by the Board of Trustees. Election to emeritus membership shall be based on the recommendation of the component society and the approval of the Board of Trustees. (c) Associate Membership. Any commissioned medical officer in the United States Army, United States Air Force, United States Navy, or United States Public Health Service, or any physician in the employ of the Veterans Administration, not licensed to practice in the State of Mississippi, stationed in Mississippi, members of medical faculties of medical schools in Mississippi, approved by the American Medical Association, who are not licensed to practice in the state, any hospital intern, or any hospital resident in Mississippi, may, on election to associate membership by the component society in whose jurisdiction the physician resides become an associate of the Mississippi State Medical Association. Associate members shall not vote or hold office. (d) Honorary Membership. A layman who has rendered meritorious service may on approval and nomination by the Judicial Council be elected to honorary membership by majority vote of the House of Delegates. Honorary members shall not vote or hold office.

Section 4. Dues and Assessments. A per capita assessment determined by the House of Delegates shall constitute the dues of the Association, which assessment shall be collected from all active members by the respective secretaries of the

component societies, provided that new members shall be accepted on payment of three-fourths of annual dues after May 1 and one-half of annual dues after September 1. Each active member shall pay the prescribed dues to the officer designated by the component society for transmittal to the Executive Secretary of the Association. Dues shall include a subscription to the official publication of the Association. (a) Members Excused From Payment. The Board of Trustees may, by majority vote, excuse a member from payment of dues because of undue hardship or similar circumstances warranting special consideration provided that the component society shall have excused in full the payment of dues for periods exceeding one year. Such circumstances shall be interpreted to include extended illness and temporary disability. Members who shall have attained age 70 and who have been active members of the Association for any 10 consecutive years may, upon request, be exempt from dues for life effective January 1 after the 70th birthday, and such exemption shall continue so long as the member continues in good standing in his component medical society. (b) Emeritus Members. Physicians who have been elected emeritus members shall not be required to pay dues in the Association. (c) Payment of Dues and Delinquency. Dues of the Association are due and payable on December 31 of the year prior to that for which dues are prescribed. Failure to pay dues by April 1 of the year for which due shall result in forfeiture of membership privileges and the removal of the member's name from the rolls of the Association. A five dollar ($5.00) reinstatement cost shall be assessed against any member who is delinquent by reason of non-payment of dues after April 1 of the year for which dues are payable. A member in good standing who is called to active duty with the Armed Forces of the United States other than in the regular component shall be carried as an active member without payment of dues until such time as he is released from military service.

Section 5. American Medical Association. Members of this Association desiring to be members of the American Medical Association may pay the dues or apply when eligible, for legal exemption from the dues of the American Medical Association. Those desiring to do so may pay their dues to the Executive Secretary whose duty shall be to transmit them to the American Medical Association and to obtain proper credits and receipts therefor.[1]

Section 6. Revocation of Emeritus or Associate Membership. Any emeritus or associate membership may be revoked by two-thirds vote of the House of Delegates when, in the opinion of the House of Delegates, the conduct or actions of the emeritus or associate member violates any of the principles of the code of ethics or whose conduct or actions are not becoming to the honor conferred.

Chapter II
ANNUAL AND SPECIAL SESSIONS

Section 1. Time and Place. An annual session shall be held as required by Article V, Section 1, the Constitution of the Mississippi State Medical Association, which session shall in any event be held prior to the annual session of the American Medical Association. The place of the state session shall be fixed in accordance with Article V, Section 2, the Constitution of the Mississippi State Medical Association.

Section 2. Special Session. A special session of the Association or of the House of Delegates may be called by the President, with the approval of the Board of Trustees. The Board of Trustees is empowered to call a special session by majority concurrence.

Section 3. Inviting an Annual Session. A component society desiring the Association and House of Delegates to meet in annual session in a city within its jurisdiction may submit an invitation in writing or verbally through its representative to the House of Delegates at the annual session concerned with the selection of the site for the next regular scheduled meeting. The dates and site of the annual session selected may be changed by majority vote of the Board of Trustees in an emergency requiring such a change.

Section 4. Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members
(b) Emeritus members
(c) Associate members
(d) Honorary members
(e) Invited guests
(f) Medical students of American Medical Association approved medical schools who are certified to the Executive Secretary of the Association by their respective deans.
(g) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the Executive Secretary of the Association by their respective hospital superintendents in event they are not associate members of the Association.
(h) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the Executive Secretary by their Post or Base Surgeons or Commanding Officers.

Section 5. Indebtedness. A member shall not be permitted to register unless all current indebtedness to both the Association and component of proper jurisdiction has been paid.

Section 6. Admittance. Admittance to any meeting of the House of Delegates, any scientific section, or any of the various exhibits at an annual session of the Association shall be limited to members in good standing, duly registered and invited guests, members in good standing of the Woman's Auxiliary to the Mississippi State Medical Association, duly accredited and registered members of the Press, and accredited technical and scientific exhibitors.

Chapter III
GENERAL MEETING

Section 1. Participation. The general meeting shall include all registered members and guests, who shall have equal rights to participate in the proceedings and discussions, but no member shall vote on any question coming before a section of the general meeting except those who have registered as members of such sections. Each section of the general meeting shall be presided over by its chairman. The address of the President and the Distinguished Service Oration shall be delivered before the general meeting at such time and place as may be arranged.

Section 2. Order. The order of exercise, papers, and discussions as set forth in the official program shall be followed from day to day until it has been completed. But no section shall be allowed to place more than five papers on its program, nor more than two invited guest essayists (out-of-state or non-member). When a section program is not completed within the time assigned, it shall not be allowed to continue into that assigned to another section.

Section 3. Time Restrictions. No address or paper before the Association, except those of the President and Orator, shall occupy more than twenty minutes in its delivery, except that guests may be allowed thirty minutes; and in formal discussion no one shall speak more than five minutes; and in informal discussion no one shall speak more than three minutes and not more than one time.

Section 4. Essayists. With the exception of the invited guests, the essayists must be members of the Association. No name shall appear more than once on the printed program

[1] Became effective Jan. 1, 1972.

to discuss a paper before the regular scientific sections unless such person qualifies for membership as provided in these By-Laws.

Section 5. Papers. All papers read before the Association shall be its property. Each paper must be read by its author, and must be deposited with the Secretary when read.

Section 6. Failure to Read Paper. No author listed on the program who fails to read a paper at the session may be allowed a place on the program of the next annual session, but if the author, being unable to attend, shows his good intent by forwarding his paper to the Secretary before the annual session, he shall not suffer the penalty.

Chapter IV
SCIENTIFIC SECTIONS

Section 1. Designation of Sections. The scientific sections of the Association shall be as follows: (a) Section on Medicine, (b) Section on Surgery, (c) Section on Preventive Medicine, (d) Section on Eye, Ear, Nose and Throat, (e) Section on Pediatrics, (f) Section on Obstetrics and Gynecology, (g) Section on General Practice and (h) Section on Anesthesiology.

Section 2. Section Officers. Each scientific section of the Association shall, as the last order of business during its regular meeting, elect a chairman who shall serve for a period of one year. A majority of votes cast shall be necessary to elect. Additionally, each section shall elect a secretary whose term of office shall be for a period of three years and so arranged that secretaries shall be elected by their respective sections at the same annual meeting as follows: (1) Sections on General Practice, Anesthesiology, and EENT, (2) Sections on Obstetrics and Gynecology and Preventive Medicine, and (3) Sections on Pediatrics, Surgery, and Medicine.

Section 3. Program. The Council on Scientific Assembly shall place any paper in its proper section. The Council shall so arrange the program that no one section shall be given precedence over others two years in succession.

Chapter V
HOUSE OF DELEGATES

Section 1. Apportionment and Representation. Each organized county shall be entitled to representation in all regular and special sessions of the House of Delegates, one delegate and one alternate for each fifty members in the county and one delegate and one alternate for each fraction thereof, but each organized county holding a charter from this organization having made its annual report and paid its assessments, as provided in this Constitution and By-Laws shall be entitled to at least one delegate and alternate, said alternate delegates to act only in the absence of the delegate or delegates from the respective counties. No county in a component society shall be without representation in the House of Delegates; each shall be entitled to one delegate and one alternate without regard to total membership. No alternate may be seated at any regular or special session of the House of Delegates unless the delegates elected from that county shall be absent or otherwise unable to participate in the proceedings. In the event that neither the delegate nor the alternate is able to attend the regular or special session to which they have been accredited, then any *bona fide* resident of the county may, if properly registered, qualify himself as a delegate. No representative of the component society shall be seated in the House of Delegates until all his dues, assessments, and obligations to the component society have been paid. Delegates and alternates shall be elected by their respective component societies for terms of not less than two years and shall assume office on the first day of the annual session following their elections; they shall be *bona fide* residents of the counties which they represent. Their names shall be reported to the Central Office of the Association not later than thirty days prior to the first day of the annual session. Representatives of component societies shall be seated in the House of Delegates only following their proper registration of credentials from the component societies they represent.

Section 2. Meetings and Attendance. The House of Delegates shall meet annually on the first day of the annual session of the Association. The House of Delegates shall meet for the conclusion of business on the last day of the annual session immediately following the adjournment of the last general or scientific session, provided that these requirements shall not operate to prevent such other meetings of the House of Delegates during the annual session as the House itself may order or the President or Speaker may deem necessary, but no such meetings may be called at times which would conflict with the scheduled general or scientific session. Duly registered members and guests may attend all meetings of the House of Delegates provided that they occupy a distinctly separate section of the meeting hall or auditorium and further provided that they shall not be permitted to participate in any phase of the meeting of the House of Delegates except on invitation of that body. By majority vote, the House of Delegates may enter into executive session, during which time only qualified delegates and officers of the Association may remain in attendance.

Section 3. Quorum. A three-fifths majority of registered and duly seated delegates of this Association shall constitute a quorum.

Section 4. Order of Business. The order of business shall be conducted at the pleasure of the House of Delegates, provided it shall not be in conflict with either these By-Laws or the Constitution. Meetings shall be conducted according to *Sturgis Standard Code of Parliamentary Procedure*, and within the bounds of courtesy and this Constitution and By-Laws. Generally, the order of business shall be:

(1) Adoption of the Transactions of the previous meeting.
(2) Reports of Boards, Councils and Committees.
(3) Reports of Presidential Committees.
(4) Special Orders.
(5) Unfinished Business.
(6) New Business.

Section 5. Memorials and Resolutions. No memorials or resolutions shall at any time be issued in the name of the Mississippi State Medical Association by any officer or member thereof until such memorial or resolution has been approved and adopted by the House of Delegates or Board of Trustees.

Section 6. Duties and Responsibilities. It shall, through its officers and otherwise, give diligent attention to foster the scientific work and spirit of the Association, and shall constantly study and strive to make each annual session a stepping stone to future ones of higher interest. It shall consider and advise the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto. It shall make careful inquiry into the condition of the profession of each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in the counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county in the state has been brought under medical society influence. It shall encourage postgraduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the component societies. It shall elect representatives to the House of Delegates of the American Medical Association

in accordance with the Constitution and By-Laws of that body, the term of office to begin on January 1 of the year following that of the elections and continuing for two successive years. It shall, upon recommendation of the Board of Trustees, provide and issue charters to counties organized to conform to the spirit of the Constitution and By-Laws.

Section 7. Reference Committees. Business brought before the House of Delegates will normally be referred by the Speaker for hearing, debate, and recommendation to a reference committee. Sufficient reference committees shall be appointed by the President to expedite and assist in the deliberations of the House of Delegates. Such committees shall consist of not less than three nor more than five members, all of whom shall be members of the House of Delegates, who shall serve only during the regular or special session for which appointed. Any member of the Association shall have the privilege of appearing before a reference committee on any issue being considered. Additionally, reference committees may permit the appearance of any individual who, in the opinion of the committee, can assist its deliberations.

Chapter VI
ELECTION OF OFFICERS

Section 1. Ballot. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect.

Section 2. Nominations. The House of Delegates on the first day of the annual session shall select a Committee on Nominations consisting of nine members of the House of Delegates, one from each Association District. It shall be the duty of this committee to consult with the members of the Association and to hold one or more meetings at which the best interests of the Association and of the profession of the state for the ensuing year shall be carefully considered. The committee shall nominate to the House of Delegates three names for each general officer vacancy and two names for all other offices. No two candidates for President-elect may be named from the same county. Nominations for appointment to membership on the Mississippi State Board of Health shall be made by the House of Delegates in accordance with Section 7024, Mississippi Code of 1942, provided that six names shall be submitted, three of whom shall be elected and their names submitted to the Governor as nominees from each district, provided no member shall be nominated who has served two consecutive terms. The House of Delegates shall nominate five physicians when vacancies occur on the Board of Trustees of Mental Institutions which nominations shall be submitted to the Governor in accordance with law.

Section 3. Report of Nominations. The House of Delegates shall receive the report of the Committee on Nominations and elect officers, Trustees, and Council members on the last day of the annual session.

Section 4. Nominations from the Floor. Nothing in this Chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Section 5. Executive Secretary. The Board of Trustees shall select and appoint on Executive Secretary as elsewhere prescribed in the Constitution and By-Laws of the Association.

Chapter VII
DUTIES OF OFFICERS

Section 1. President. The President shall have general supervision over all meetings of the various bodies of the Association, shall appoint all committees not otherwise provided for, shall deliver an annual address at such time and place as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall fill by appointment all vacancies occurring during his tenure of office among the general officers and on the Board of Trustees and Councils and shall be empowered to appoint such committees on an *ad hoc* basis as may be desired or required to conduct the affairs of the Association. He shall be an *ex officio* member of all Councils and committees. He shall be the real and acknowledged head, as well as the personal representative, of the medical profession of the State of Mississippi during his term of office, and insofar as practicable, shall visit by appointment the various sections of the state and the component societies of the Mississippi State Medical Association and assist the Trustees in their tasks of aiding and strengthening the component societies and in making their work more useful.

Section 2. President-elect. The President-elect shall be in charge of the work of organization, including membership, under the direction of the President, and shall exercise these duties and advise with the Vice Presidents and with the Board of Trustees in this phase of their activity. He shall be an *ex officio* member of all Councils and committees. He shall succeed to the presidency upon the event of the death, resignation, or removal from office of the President. This automatic succession shall not operate to disqualify him from serving the next regular term of office unless he has served more than six months as President.

Section 3. Vice Presidents. The Vice Presidents shall assist the President in the discharge of his duties. They shall further assist the President-elect in the work of organization, including membership in their respective areas, and in promoting the welfare of the Association and the profession of the state.

Section 4. Speaker. A Speaker shall be elected for a term of three years. This officer may be chosen from the membership of the Association, irrespective of any affiliation with the House. The Speaker shall familiarize himself with the rules and usages of parliamentary procedure, with the laws of the House. On him shall devolve the duty of bringing before the House through the various officers and chairmen all reports and other matters that are to receive its attention. He shall preside at all meetings of the House and perform the duties usual to the position and office of chairman except in the appointment of committees, which shall be the privilege of the President.

Section 5. Vice Speaker. A Vice Speaker shall be elected for a term of three years to run concurrently with that of the Speaker. The Vice Speaker shall assist the Speaker in all duties prescribed in these By-Laws.

Section 6. Secretary-Treasurer. The Secretary-Treasurer shall be elected for a term of three years. He shall perform such duties ordinarily devolving on a secretary of a corporation by law, custom, or parliamentary usage and shall enjoy the rights and perform such other duties as may be granted or imposed in the Constitution and these By-Laws. He may delegate such duties as are herein described to the Executive Secretary who shall be responsible therefor. He shall be an *ex officio* member of all Councils and committees.

Section 7. Executive Secretary. The Executive Secretary shall be appointed by the Board of Trustees and shall serve at the pleasure of the Association. He need not be a member of the Association nor a physician. He shall maintain a Central Office for the Association and shall be responsible for the management and proper functioning of the Central Office to the President of the Association and the Board of Trustees. He shall attend all sessions and meetings of the Association, the House of Delegates, the Board of Trustees, and shall serve at all times to perform such other duties as may be deemed beneficial to the Association by the President and Board of Trustees. He shall assist elected officers, Councils, committees, and Trustees in the performance of their duties. Under instructions from the President, he shall conduct a comprehensive program of public education and all such other activities as may disclose favorably to the public at large the aims, objectives, and goals of service of the

medical profession in Mississippi. He shall, when requested, place himself in position to assist any of the component societies of the Association and he shall attend meetings of the component societies when invited by officers thereof. He shall be made custodian of records, books and papers belonging to the Association and he shall keep account of and promptly place under the supervision of the Secretary-Treasurer such funds as may be delivered into his hands in the name of the Association. He shall give bond at the expense of the Association in such amount as may be required. He shall provide for the registration of the members and delegates at the annual session and cooperate in preparing for and arranging all functions of the Association, including the annual session. He shall procure an exact transcript of all proceedings of the House of Delegates. He shall maintain a register of all legal practitioners in Mississippi and he shall maintain detailed and exact records of the membership with regard to component societies, the Mississippi State Medical Association, and the American Medical Association. He shall issue evidence of membership to each physician who pays the annual assessment and is accepted in the Mississippi State Medical Association. He shall maintain close and complete liaison with the American Medical Association and shall keep the component societies informed of activities, programs, and mandates of both the state Association and the American Medical Association. He shall publish from the Central Office such memoranda, bulletins, and miscellaneous publications as may be directed by the President, the Board of Trustees, and the House of Delegates. He shall conduct the official correspondence of the Association as he may be directed. He shall employ such assistants as may be required, upon authorization of the Board of Trustees. He shall supply each component society with blank forms to be used in connection with membership and reports. He shall maintain records of monies paid by the component societies for assessments and dues. He shall prepare and publish under the direction of the President and Board of Trustees such programs as may be necessary for official functions of the Association. He shall be reimbursed for expenses incurred in the performance of his duties, separately and in addition to his regular compensation.

Chapter VIII
BOARD OF TRUSTEES

Section 1. Board of Trustees. The Board of Trustees shall be the executive and governing body of the Association during vacation of the House of Delegates. It shall consist of nine members, one from each Association District, where terms of office shall be three years and so arranged that only three members are elected annually. A Trustee shall not serve more than three consecutive terms. During vacation, the Board of Trustees shall exercise the powers conferred upon the House of Delegates by the Constitution and these By-Laws, provided that in the exercise of these powers thus conferred, the Board of Trustees shall neither consider nor act to contravene any action, mandate, or policy of the House of Delegates which may still be in effect.

Section 2. Officers of the Board. The Board of Trustees shall elect from its membership a Chairman, a Vice Chairman, and a Secretary for terms of one year during the last day of the annual session following adjournment of the House of Delegates. These officers of the Board shall compose its Executive Committee. The duties of the Secretary may be delegated to the Executive Secretary who shall maintain such special records and transcripts of meetings as the Board may desire.

Section 3. Meetings of the Board. The Board of Trustees shall meet daily during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of any three members of the Board.

Section 4. Executive Committee. The Executive Committee of the Board of Trustees shall be empowered to act in behalf of the Board on all matters delegated to it by majority vote of the Board. The acts of the Executive Committee, however, shall be subject to confirmation by the Board.

Section 5. Reports of the Board of Trustees. The Board of Trustees shall make an annual report to the House of Delegates and such supplemental reports as necessity may require at a time designated in the regular transaction of the business of the House. The report shall be made by the Chairman, the Vice Chairman, the Secretary, or the Executive Secretary. The reports of the Board shall be made a portion of the annual transactions and proceedings of the Association.

Section 6. Duties of Trustees. Each Trustee shall be organizer and arbiter for his Association District. He shall visit the component medical societies within his District during each year and shall make an annual report of his activities and of the condition of the medical profession of each county of his District. Each Trustee shall be reimbursed for expenses incurred by him in traveling within his District or attending special meetings in the performance of his official duties, which will be allowed upon presentation of an itemized and documented account. This provision shall not be construed to include his expenses in attending the annual session of the Association.

Section 7. Public Policy. The Board of Trustees shall have the right to communicate the views of the medical profession and of the Association in the State of Mississippi with regard to matters of medical science, health, sanitation, and allied spheres of activity. It shall approve all memorials and resolutions issued but shall not issue memorials and resolutions heretofore prohibited in these By-Laws.

Section 8. Association Districts. The State of Mississippi shall be subdivided into Association Districts by counties, provided that all counties in a component society shall be in one Association District. These districts are defined as follows:

District 1: Bolivar, Coahoma, Humphreys, Leflore, Quitman, Sunflower, Tallahatchie, Tunica, and Washington.

District 2: Benton, DeSoto, Lafayette, Marshall, Panola, Tate, Tippah, and Yalobusha.

District 3: Alcorn, Calhoun, Chickasaw, Clay, Itawamba, Lee, Lowndes, Monroe, Noxubee, Oktibbeha, Pontotoc, Prentiss, Tishomingo, and Union.

District 4: Attala, Carrol, Choctaw, Grenada, Holmes, Montgomery, and Webster.

District 5: Hinds, Issaquena, Leake, Madison, Rankin, Scott, Sharkey, Simpson, Smith, Warren, and Yazoo.

District 6: Clark, Kemper, Lauderdale, Neshoba, Newton, and Winston.

District 7: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Pearl River, Perry, and Wayne.

District 8: Adams, Amite, Claiborne, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall, and Wilkinson.

District 9: Hancock, Harrison, Jackson, and Stone.

Chapter IX
COUNCILS

Section 1. Councils. Councils of the Association shall be elected standing bodies of the House of Delegates, responsible thereto. There shall be a Council on Medical Service, a Council on Scientific Assembly, a Judicial Council, a Council on Constitution and By-Laws, a Council on Legislation, a Council on Budget and Finance, an Editorial Council, and a Council on Medical Education. A Council member shall not serve more than three consecutive terms.

Section 2. Council on Medical Service. The Council on

Medical Service shall be charged with the responsibilities of ascertaining and studying all aspects of medical care in Mississippi. It shall examine and make available all facts, data, and opinion on timely and adequate medical care. It shall investigate social and economic aspects of medical care and report its evaluations and findings. It shall suggest means of distribution of adequate quality medical service to the public consistent with the policies of the Association. It shall act as a factfinding and advisory body of the Association. Under its jurisdictions, there shall be assigned the activities of the Association in medical service, emergency service programs, indigent care, and allied medical agencies. There shall be one member from each Association District elected for a term of three years and so arranged that only three members shall be elected for full terms each year. The Council on Medical Service shall appoint Committees on Occupational Health, Maternal and Child Care, Mental Health, Blood and Blood Banking, and Nursing. Each committee shall consist of not less than five nor more than seven members appointed for periods of not less than one nor more than three years.

Section 3. Council on Scientific Assembly. The Council on Scientific Assembly shall be composed of the Secretary-Treasurer and the chairman and secretaries of the several scientific sections. The Secretary-Treasurer shall be chairman of the Council. Upon this Council shall devolve the duties and responsibilities of planning the annual session to include all scientific activity and the programming and scheduling of annual session events. The Council shall be empowered to appoint such committees for terms not to exceed one year as may be necessary to assist in the discharge of these duties.

Section 4. Judicial Council. The Judicial Council shall consist of nine members elected for terms of three years each, one from each Association District. The Judicial powers of the Association shall be vested in this Council whose decision shall be final. The Council shall have jurisdiction in all questions involving membership in the Association, all controversies arising under the Constitution and these By-Laws, interpretation and application of the Principles of Medical Ethics of the American Medical Association, controversies between two or more component societies of the Association and among members of the Association. The Council shall have appellate jurisdiction in questions and controversies referred to the state Association by appropriate and authorized bodies of component medical societies. Appeals shall be perfected within six months following the date of decision by the constituted authority of the component society. The Council, under these several authorites, may conduct such hearings as may be necessary and after due and legal processes may, by majority opinion, censure, suspend, or expel any member for infraction of the Constitution or these By-Laws.

Section 5. Council on Constitution and By-Laws. The Council on Constitution and By-Laws shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be referred all suggested amendments and changes in the Constitution and By-Laws of the Association for recommendation to the Board of Trustees and House of Delegates.

Section 6. Council on Legislation. The Council on Legislation shall consist of nine members, one from each association district, elected by the House of Delegates for terms of three years each which are so arranged that three members are elected annually. This Council shall analyze proposed legislation, recommending to the Board of Trustees courses of action for securing laws in the interests of public health, scientific medicine, as well as medical practice. It shall study and report the need for new and remedial legislation designed to serve the best interests of the state and nation. This Council shall be responsible to the Board of Trustees.

Section 7. Council on Budget and Finance. The Council on Budget and Finance shall consist of five members elected by the House of Delegates for terms of three years each which are so arranged that not more than two members shall be elected annually. This Council shall receive reports of the finances of the Association and to it shall be referred all matters pertaining to the annual budget. The Council shall report annually to the House of Delegates, making specific recommendations on the annual budget of the Association. This Council shall be responsible to the Board of Trustees.

Section 8. Editorial Council. The Editorial Council shall consist of the Editor and the Associate Editors, elected by the House of Delegates to serve two years, and the former shall serve as chairman. To this Council shall be referred all reports of scientific subjects and all scientific papers and discussions presented before the Association and its component societies. The Council shall consider for publication in the official organ of the Association such papers, reports, and other data as may serve to further and advance scientific medicine in Mississippi. It shall exercise editorial authority over the official organ of the Association. This Council shall be responsible to the Board of Trustees.

Section 9. Council on Medical Education. The Council on Medical Education shall consist of three members elected by the House of Delegates for terms of three years each. To this Council shall be assigned the responsibilities of encouraging undergraduate and postgraduate study of medicine, licensure, and facilities for medical education in the state. This Council shall be responsible to the Board of Trustees.

Chapter X
COMMITTEES OF THE BOARD OF TRUSTEES

Section 1. Committees of the Board of Trustees. Standing committees of the Board of Trustees shall consist of the Advisory Committee to the Medical Auxiliary, Peer Review Committee, the Committee on Publications, and the Committee on Medicine and Religion. All committees of the Board of Trustees shall be appointed by the Board for terms specified unless their selection is otherwise prescribed.

Section 2. Advisory Committee to the Medical Auxiliary. The Advisory Committee to the Medical Auxiliary shall consist of three members appointed for terms of three years each. The committee shall be charged with the responsibility of advising the Woman's Auxiliary to the Mississippi State Medical Association on matters of organization and program activity relating to the supportive role of the Auxiliary in its work with the Association.

Section 3. Peer Review. The Committee on Peer Review shall consist of nine members, one from each Association district, appointed for terms of three years each so as to provide for appointment of three members annually. Members of this committee shall not simultaneously serve on any disciplinary body of the Association or its component medical societies. To this committee shall be assigned the work of peer review, including but not limited to resolution of differences between patient and physician, review of the quality of medical care, adequacy and/or reasonableness of fees, whether due or paid from private or public sources, utilization of health care resources, and liaison with private and public sources of medical care financing. The committee is empowered to encourage a response from any member of the Association in writing or by personal appearance, authority to initiate investigations on its own motion, and authority to file charges against a member in the name of the committee before the Judicial Council or a disciplinary body of a component medical society. Under no circumstances, however, shall the Committee on Peer Review exer-

cise any disciplinary function nor shall it be empowered to alter the status or standing of any member. The committee shall be empowered to prescribe its rules of operation which shall not be in conflict with the policies or By-Laws of the Association. The committee shall also encourage and assist component medical societies in forming Committees on Peer Review at the local level.

Section 4. Committee on Publications. The Committee on Publications shall consist of six members. These shall consist of the Editor, the two Associate Editors, and three others, the three latter being appointed by the Board of Trustees for terms of three years which are so arranged to provide for appointment of one such member annually. The chairman of the committee shall be designated by the Board. The committee shall implement instructions and policies of the Board of Trustees relating to the official JOURNAL of the Association. Additionally, the committee shall study and recommend to the Board policy proposals relating to organization and production of the JOURNAL, reporting annually its deliberations.

Section 5. Committee on Medicine and Religion. The Committee on Medicine and Religion shall consist of six members appointed for terms of three years each and so arranged to provide for appointment of two members annually. The committee shall be responsible for formulating a program in the field of medicine and religion and for carrying out such assignments as may be made in this connection by the Board of Trustees.

Section 6. Committee on Long-Range Planning. The Committee on Long-Range Planning shall consist of five members appointed for terms of five years each and so arranged to provide for appointment of one member annually. This committee shall receive charges from the Board of Trustees and shall assess developments and requirements in fields of association activity, making recommendations for courses of action to achieve maximum possible effectiveness in all fields of association activity.

Chapter XI
RULES AND CONDUCT

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Chapter XII
COMPONENT SOCIETIES

Section 1. Component Societies. All component societies now in affiliation with this Association or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Board of Trustees and approval by the House of Delegates, receive a charter from and become a component part of this Association. The Board of Trustees and House of Delegates, on recommendation by the Judicial Council, shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and By-Laws.

Section 2. Number of Societies. Only one component medical society shall be chartered in any county but nothing in this section shall be construed as to prohibit unofficial organization of medical clubs or other county level groups of physicians whose purpose it is to further and advance scientific medicine and postgraduate medical education.

Section 3. Members of Societies. Each component society shall judge the qualifications of its own members, but as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who is qualified under Chapter I, Section 1, of these By-Laws shall be eligible for election to membership. Before a charter is issued to any component society, full and ample opportunity shall be given to every such physician in the county to become a member.

Section 4. Right of Appeal. Any physician who may feel aggrieved by the action of the society of his county or District in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Judicial Council, which, upon a majority vote, may permit him to petition for membership in an adjacent society.

Section 5. Evidence of Appeals. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and most fairly present the facts, but in case of every appeal, efforts at a conciliation and compromise shall precede all such hearings.

Section 6. Area Jurisdiction. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 7. Professional Authority. Each component society shall have general direction of the affairs of the profession in its jurisdiction and shall constantly use its influence to the moral and professional betterment of its physicians, to the end that the membership shall embrace every qualified physician in its jurisdiction.

Section 8. Meetings. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall especially be encouraged to do postgraduate work, and to give the society first benefit of such labors. Official positions and other preferments shall be unstintingly given to such members.

Section 9. Delegates. Each county shall be entitled to representation in the House of Delegates of this Association, one delegate for each fifty members or fraction thereof. Delegates shall be elected for terms of not less than two years and societies shall report such elections to the Executive Secretary of the Association in no event later than thirty days before the annual session.

Section 10. Duties of Component Society Secretaries. The secretary of each component medical society shall perform such duties as are usual and customary to his office. He shall maintain the official roll of membership for his society, shall collect dues and assessments, and shall make official reports as elsewhere prescribed in these By-Laws to the Association, transmitting dues in behalf of component society members. He shall conduct the official correspondence of his component medical society.

Chapter XIII
FISCAL YEAR

The fiscal year of the Association and its component county societies shall begin January 1 each year and end on December 31 following, but membership in the state Association shall not lapse until April 1 of that year.

Chapter XIV
AMENDMENTS

These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, after the amendment has laid upon the table for one day.

Chapter XV
REPEALING AUTHORITY

Upon adoption of these By-Laws, all previous By-Laws, motions of record, mandates, policies, rules and regulations in conflict therewith are hereby repealed, except that officers elected to serve in the Association and its component societies shall continue their incumbency until the completion of their previously prescribed terms and their successors elected under the current By-Laws.

MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 30-Dec. 4, 1974, Portland, Ore. Annual Convention, June 15-19, 1975, Atlantic City, N. J. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 68th Annual Scientific Meeting, Nov. 18-21, 1974, Atlanta. SMA, 2601 Highland Ave., Birmingham, Ala. 35205.

Tennessee Valley Medical Assembly, Annual Meeting, Sept. 30-Oct. 1, 1974, Chattanooga. Mrs. F. M. Richardson, Executive Secretary, 960 E. Third St., Chattanooga, Tenn. 37403.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 11-13, 1974, Biloxi. Mrs. Alyce Palmore, Executive Secretary, P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 107th Annual Session, May 5-8, 1975, Biloxi. Charles L. Mathews, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, The Field Clinic, Centreville 39631, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Max Pharr, B6 Medical Arts Building, 1151 N. State St., Jackson 39201, Secretary.

Claiborne County Medical Society, First Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, P.O. Box 147, Port Gibson 39150, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday, April, and First Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, P.O. Box 128, Summer 38957, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, and November. J. H. Gaddy, 4502 15th St., Gulfport 39501, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando 38632, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian 39301, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez 39120, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. Robert B. Townes, 1196 Mound St., Grenada 38901, Secretary.

Northeast Mississippi Medical Society, First Thursday, March, June, September, and December. S. Jay McDuffie, Nettleton 38858, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford 38655, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune 39466, Secretary.

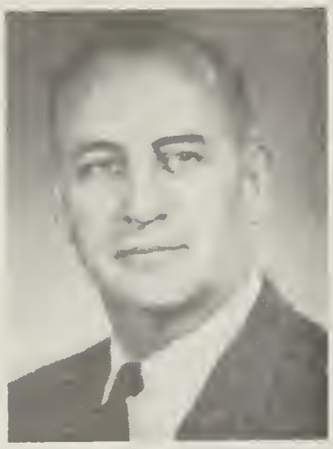
Prairie Medical Society, Second Tuesday, March, June, September, and December. W. C. Welch, P.O. Box 5448, Mississippi State 39762, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Jeff Hodges, 1365 Market St., Pascagoula 39567, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb 39648, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie St., Hattiesburg 39401, Secretary.

West Mississippi Medical Society, Third Monday, January, March, May, September, October and November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, The Street Clinic, Vicksburg 39180, Secretary.



The President Speaking

A Process of Leadership

J. T. DAVIS, M.D.
Corinth, Mississippi

NEVER BEFORE in the annals of the medical profession has the need been greater for strong unified action on the part of organized medicine than today. The private practice of medicine, the doctor-patient relationship, the confidentiality of medical information and even the very existence of the private practicing physician as an individual are being challenged and seriously threatened.

Cognizance of these facts usually raises the question; "What can we do to improve the situation and to create a favorable practice environment?"

I believe we can solve the problems and issues of the day by an organizational process that also provides the physician leaders of tomorrow.

The present trend is to shorten the terms of office of those in the higher echelon of command and make way for the younger men. I could not agree more wholeheartedly with this idea. But I would urge an orderly transition directed at exchanging the "young" for the "younger." In this way I believe we can strengthen medicine at that most critical point—the local community.

The "younger men" elected to high office should be knowledgeable and experienced physicians seasoned by civic and professional service at the county and state committee level. Inexperience and a closed mind have no place at the top level and may well prove disastrous. We have seen a few examples of this at the Federal level.

Most officers at the state and national levels of medical organization today are "old men" in experience only. Most have climbed a ladder to their present position. They started at the bottom of that ladder and served in various capacities in their county and state societies with distinction. To do this one must become a member—then a member willing to work—equipped with an open mind to approach problems so as to generate an unbiased opinion. To be a member of the "vociferous minority" (provided one has studied his lesson) is even preferred to the "fork and knife" member who has no knowledgeable opinion but rather just an "educated guess."

The profession that has an organizational process for training the young physician for leadership may be assured of survival in this uncertain, changing world of tomorrow. ★★★

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EDITORIALS

MSMA Dues: More Return for Your Investment

A frequently asked question is why are state medical dues so high and what does one receive in return. This is not an uncommon question and is not necessarily peculiar to our organization.

Recently our Executive Secretary, Charles Mathews, and Executive Assistant Bill Robert visited the South Central Medical Society at its quarterly meeting in McComb. The discussion was largely related to state medicine and bills in the state legislature that were health related. I was most impressed with the effort being made to keep our membership informed of impending legislation that affects us all. The thought occurred to me that such a meeting should be held in each society annually and that a special effort should be made to increase attendance for this particular meeting.

It might be interesting to note that there were 2200 health related bills submitted to the present congress of the U.S. during the past session. Certainly no congressman could even havc a passing knowledge of them all and frequently they are not well informed on even a few.

Percentage wise on the state level the proposition is well akin. Without organization to sift these measures and keep medicine informed of their potential hazards or merits, as the case may be, no doctor could stay in a position to combat or foster any of these.

Our state association is an efficient organization composed of an able staff and governed by a group of selfless trustees who make a far greater contribution to my interests and yours than is generally apprcciated.

In answer to the question at the beginning of this editorial I know of no organization to which I contribute where I feel my money is more judiciously used and wisely spent or wherc I get more return for my investment.

W. Moncure Dabney, M.D.
Editor, Journal MSMA
Crystal Springs, Miss.

A Challenge for Voluntary Restraint

Wage/price controls expired on April 30, 1974, for thc total cconomy. Debate over the success of the controls—or lack of it—will continue for decades. When the controls began in August 1971, many said that "they would provide a way to break the back of inflation" which at that time was about 4½ per ccnt annually. If that was the goal, then the

effort failed miserably. It takes $113.40 today to buy the same consumer goods that sold for $100 in August 1971.

One thing is certain, however, even after expiration of wage/price controls there is strong public support for some type of mechanism to restrain rising health care costs. Wage/price controls on health services were the last to expire. There was broad support in the Legislative and Executive branches to continue such controls for health services.

More recently HEW Secretary Caspar Weinberger stated that the expiration of wage/price controls "presents one of the most serious challenges the health care industry has ever faced. . . . For with or without controls the cost of health care remains the single most important problem in the industry today, far more important than the related issues of quality and access."

The association's House of Delegates recognized this challenge at the recent annual session when it unanimously passed Resolution No. 8, which resolved ". . . that the medical profession exert every effort to combat inflation by voluntarily contributing its best efforts to restrain rising costs." The AMA has proposed four guidelines for physicians in evaluating their fee structure: (1) The physician has the right to raise his fees to cover increased practice costs resulting from inflation; (2) the physician, as a consumer in an inflationary economy, may be forced to make fee adjustments to counteract the effects of inflation on his personal life; (3) the physician should aim to increase his productivity so that he can raise his profit margin without setting sharply higher fees; and (4) in some cases, where federal controls have resulted in inequities or severe personal loss, more extreme fee increases may be necessary.

To assist physicians in making equitable decisions about fees, the AMA will soon offer quarterly regional data on the fluctuation of practice costs and on the inflation rate. The data will be published in the AMA News which is read by some 360,000 physicians. The performance of physicians under the discriminatory wage/price control program was exemplary. Physicians' fees increased at a rate far below that of the rest of the economy. The challenge now is for voluntary restraint that will disprove those who say "the sky will become the ceiling because the lid is off." Organized medicine plans to meet that challenge.

CHARLES L. MATHEWS
Executive Secretary

PSRO to Begin in Mississippi

Barring unforeseen circumstances, the Mississippi Foundation for Medical Care, Inc., will join 12 other Professional Standards Review Organizations in beginning "Conditional Operation" of the PSRO Program. Twenty months after its enactment PSRO now begins at three levels of implementation—planning, support and conditional operation. Some 65 Professional Standards Review Organizations will begin planning and support operations.

Congress stated that its intent in enacting PSRO was to assign to the practicing medical profession all medical review activities now or in the future concerned with the Medicare, Medicaid and the Maternal and Child Health Programs. Needless to say, many are worried about the effect of this "'Congressional intent" both within and without the medical profession. Will PSRO "turn the chicken-coop over to the foxes"? Will it destroy the physician/patient relationship? Will it make quality medical care a servant to cost considerations?

Mississippi physicians have thus far looked at PSRO with a "positive eye." In 1971 the association obtained a research grant from the Department of



"Yes, sometimes modern drugs do produce some strange side effects."

H.E.W. as one of several Experimental Medical Care Review Organizations (EMCRO) to demonstrate a physician sponsored medical review system. PSRO was then on the Congressional agenda. Soon after passage of the law in 1972, major articles regarding its implications appeared in the JOURNAL MSMA.

In April 1973, the association joined the Mississippi Hospital Association in sponsoring a series of PSRO Conferences throughout the state for physicians and hospital personnel at which "PSRO experts" spoke. At its May 1973 meeting the House of Delegates directed the association sponsored Mississippi Foundation for Medical Care ". . . to proceed to implement PSRO in Mississippi as required by Public Law 92-603."

In July 1973, a PSRO Planning Committee of 21 physicians representing all specialties and geographic areas in Mississippi was formed by the MFMC. A subcommittee of the planning committee obtained a grant from the Mississippi Regional Medical Program and after several months of study formulated a "PSRO Implementation Plan for Mississippi." This later served as the basis for the foundation's application for designation and funding as the "Conditional PSRO" for Mississippi.

At the association's recent annual session, the House of Delegates again reaffirmed plans to implement PSRO in Mississippi and to seek to amend any part of the program's operation that has a deleterious effect on the physician/patient relationship. Meeting in conjunction with the association, the membership of the Mississippi Foundation for Medical Care also reaffirmed these plans.

The initial phase of PSRO operation in Mississippi can briefly be described as a six-month period concerned with organization, education and coordination. Organization will involve staffing and structuring of the Mississippi PSRO. Education and coordination will involve defining PSRO review procedures and their integration with the Medicare, Medicaid and Maternal and Child Health Programs.

Much work remains to be done that will require the continued cooperation and interest of all physicians, but with a "positive eye" toward PSRO the medical profession in Mississippi is well along the way toward answering some of those questions about the effect of a program named PSRO.

TOM H. MITCHELL, M.D., Chairman
Subcommittee on PSRO Planning
Mississippi Foundation for Medical Care, Inc.

Medico-Legal Briefs

OPHTHALMOLOGISTS HELD DUTY-BOUND TO ROUTINELY TEST FOR GLAUCOMA

Two ophthalmologists practicing as a partnership were negligent in failing to test a patient for glaucoma even though she had no symptoms of the disease, the Supreme Court of the state of Washington held.

Although the standard of the profession does not require routine testing of patients under the age of 40, because of the rarity of glaucoma in persons in that age group, the court pointed out that the test is simple, inexpensive, and harmless, and the consequence of the disease going undetected is irreversible blindness. In such circumstances, failure to perform the test amounts to negligence, the court said.

Suit was brought against the ophthalmologists by a patient who had first consulted them in 1959 for myopia. At that time she was fitted with contact lenses. She next consulted the partners in September 1963, because of irritation caused by the contact lenses. There were additional consultations in October 1963; February 1967; September 1967; October 1967; May 1968; July 1968; August 1968; September 1968; and October 1968.

Until the October 1968 consultation, the ophthalmologists considered the patient's visual problems to be related solely to complications associated with her contact lenses. On that occasion, one of the partners tested the patient's eye pressure and field of vision for the first time. The test indicated that the patient, who was then 32 years old, suffered from primary open angle glaucoma. She had essentially lost her peripheral vision, and her central vision was reduced to approximately 5 degrees vertical by 10 degrees horizontal. The ophthalmologist who administered the test estimated that she had been suffering from the disease for 10 years or longer.

In August 1969, after consulting other physicians, the patient sued the partners, alleging, among other things, that she sustained severe and permanent damage to her eyes as a result of the ophthalmologists' negligence. Judgment for the partners was entered following a verdict in their favor, and the appellate court affirmed the judgment. The patient then petitioned the Supreme Court of Washington for review.

In reviewing the patient's petition, the court noted that medical experts for both sides agreed that, in

the absence of symptoms of glaucoma, the standard of the profession did not require routine testing of patients under the age of 40, because the incidence of the disease in patients under 40 is only one out of 25,000 persons. However, the test is a simple pressure test, relatively inexpensive, and harmless if the physical condition of the eye permits. In this case, although the condition of the patient's eyes might have at times prevented administration of the pressure test, there was no evidence that the test could not have been timely given. Therefore, the court said, the patient was entitled to the same protection as afforded persons over 40, so that glaucoma could be timely detected and measures taken to arrest the disease and avoid its grave and devastating results.

In conclusion, the court said:

"Under the facts of this case reasonable prudence requires the timely giving of the pressure test to this [patient]. The precaution of giving this test to detect the incidence of glaucoma to patients under 40 years of age is so imperative that irrespective of its disregard by the standards of the ophthalmology profession, it is the duty of the courts to say what is required to protect patients under 40 from the damaging results of glaucoma.

"We therefore hold, as a matter of law, that the reasonable standard that should have been followed under the undisputed facts of this case was the timely giving of this simple, harmless pressure test to this [patient] and that, in failing to do so, the [ophthalmologists] were negligent, which proximately resulted in the blindness sustained by the [patient] for which the [ophthalmologists] are liable."

Reversing the judgment of the trial court and the decision of the appellate court, the Washington Supreme Court remanded the case for a new trial on the issue of damages only.

In a concurring opinion in which three judges joined, it was argued that liability should have been imposed on the basis of strict liability without fault, rather than negligence, on the ground that the theory of negligence implied moral blame. In this case, the ophthalmologists acted reasonably according to the standards of their profession. However, in determining who should bear the loss of their failure to administer the glaucoma test, the concurring opinion pointed out that the physicians, because of their malpractice insurance, were financially better able to bear the loss than was the patient.—*Helling v. Carey* (Sup.Ct.Wash., Docket No. 42775, Mar. 14, 1974) Reference: Darrell L. Havener, Esq., Watson, Ess, Marshall, and Enggas, 1006 Grand Ave., Kansas City, Mo. 64106.

Editor's Note: This decision may be one of the most important medical malpractice cases to be decided in several years. It is likely that the courts of some other states will follow this precedent. How many will do so is a matter of speculation.

The attorneys for the ophthalmologists are requesting the court to grant a rehearing. In view of the fact that the decision was unanimous, however, it is doubtful that the request will be granted.

The Washington Supreme Court has departed from the well-established general rule which requires physicians to conform to a standard of practice established by the medical profession. The court has ruled that the ophthalmologists, at least those in the state of Washington, must test for glaucoma in all eye examinations irrespective of the patient's age. It is impossible to forecast accurately which other tests the courts may decide, on the same basis that the Washington court applied in this case, that a physician must give routinely to every patient in order to avoid being held negligent "as a matter of law." Attempts to avoid this dangerous legal trap may result in a dramatic increase in the frequency of many medical tests for which there is not at present considered to be a reasonable medical necessity. The unavoidable consequence would be a substantial increase in the cost of medical care.

DEATHS

DEDDENS, LLOYD E., Jackson. M.D., University of Louisville School of Medicine, Louisville, Ky., 1936; interned St. Joseph Hospital, Lexington, Ky., one year; residency (surgery), same, one year; residency (urology), Grady Memorial Hospital, Atlanta, Ga., 1938-40; died April 25, 1974, age 65.

GREAVES, PEYTON R., Jackson. M.D., Jefferson Medical College, Philadelphia, Pa., 1916; interned New York City Hospitals, one year; member of MSMA Fifty Year Club; died May 28, 1974, age 85.

SCHMID, OTTO A., Jackson. M.D., St. Louis University School of Medicine, St. Louis, Mo., 1908; interned St. Louis City Hospitals, St. Louis,

Mo., one year; residency (psychiatry), St. Louis City Sanatarium for Insane, St. Louis, Mo., 1909-10; member of MSMA Fifty Year Club; died May 3, 1974, age 93.

STOKES, JACK A., Pontotoc. M.D., University of Mississippi School of Medicine, Jackson, Miss., 1960; interned, same, one year; Vice-President of MSMA, 1969; member and past president of the Mississippi Flying Physicians Association; secretary for Northeast Mississippi Medical Society; died June 1, 1974, age 43.

NEW MEMBERS

AYCOCK, LARRY B., McComb. Born Rosehill, Miss., June 8, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned City of Memphis Hospitals, Memphis, Tenn., one year; residency (Internal Medicine), University Medical Center, Jackson, Miss., 1969-72; elected by South Central Medical Society.

BURNETT, WILLIAM JOSEPH, Oxford. Born Charleston, Miss., Mar. 27, 1940; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1965; interned Baptist Memorial Hospital, Memphis, Tenn., one year; residency (ENT), University of Tennessee, 1970-73; elected by North Mississippi Medical Society.

HILLMAN, JOSEPH CARROLL, Brookhaven. Born Hattiesburg, Miss., Dec. 19, 1946; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1972; interned University Medical Center, Jackson, Miss., one year; elected by South Central Medical Society.

STEPAN, JOHN C., Vicksburg. Born Vicksburg, Miss., April 11, 1941; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1966; interned Parkland Memorial Hospital, Dallas, Tex., one year; residency (Surgery), University Medical Center, Jackson, Miss., 1967-68; residency (Radiology), University of Arkansas, Little Rock, Ark., 1970-73; elected by West Mississippi Medical Society.

WHITE, A. R., JR., Greenville. Born McComb, Miss., April 7, 1944; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1969; interned University of Alabama Hospitals and Clinics, Birmingham, Ala., one year; residency (Internal Medicine), University Medical Center, Jackson, Miss., 1970-73; elected by Delta Medical Society.

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Oct. 28-Nov. 1

NEUROLOGY AND NEUROSURGERY INTENSIVE COURSE
University Medical Center, Jackson
Oct. 28-Nov. 1

Sponsored by the University of Mississippi School of Medicine with support from the Mississippi Regional Medical Program

Coordinator:
Robert D. Currier, M.D., professor of medicine, the University of Mississippi School of Medicine, and co-director of the stroke unit of the Regional Medical Program
Armin Haerer, M.D., associate professor of medicine, the University of Mississippi School of Medicine

The content of this course will include the management of adult and children's neurological disorders. Material will be presented in seminars, discussion groups and assigned reading and rounds on the wards and clinics. Rehabilitation techniques will be included.

Dates for the one-week intensive courses to be offered this fall in EKG and radiology will soon be announced. Tentatively scheduled are one-week intensive courses in pulmonary medicine, ENT, hematology, cardiology, newborn care, pediatrics, nephrology, and urology.

FUTURE CALENDAR

Oct. 28-Nov. 1, 1974
NEUROLOGY AND NEUROSURGERY INTENSIVE COURSE

Nov. 8-9
CEREBRAL VASCULAR DISEASE CONFERENCE

Mar. 13-15, 1975
SURGERY CONFERENCE

May 5-8
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

PERSONALS

FRANK BOWEN of Carthage assumed the presidency of the University of Mississippi Medical Alumni Chapter in May.

JOHN BOWER of Jackson and UMC spoke on the current status of nephrology in Mississippi at the annual meeting of the Kidney Foundation of Mississippi. Dr. Bower is chairman of the Medical Advisory Board of the foundation.

CURTIS CAINE of Jackson was in charge of the fireworks display for the annual summer pops concert of the Jackson Symphony held at the Barnett Reservoir.

TEMPLE CARNEY of York, Ala., has opened a clinic at Scooba where he will see patients after 5:30 p.m. Monday through Wednesday and Friday.

MIKLOS H. EGYED and JOHN R. LAIRD announce their affiliation for the practice of medicine at the Newton Medical and Surgical Group, Ltd., 1011 S. Main Street in Newton.

DAVID C. ELLIOTT and BERNARD PATRICK of Jackson are members of the new Capital City Concert Band Society.

JOHN EVANS of Vicksburg was guest lecturer at the five-day stop smoking clinic sponsored by the American Cancer Society in Natchez June 9-13.

JAMES V. FERGUSON of Greenwood is new president-elect of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

VAN DYKE HAGAMAN of Jackson was presented the Southeast Region, National Rehabilitation Association's highest honor, the H. B. Cummings Award, at the annual banquet. Dr. Hagaman is an ophthalmologist.

KARL W. HATTEN of Vicksburg was guest speaker on emergency cardiac care to Mississippi Heart Association volunteers June 7 at the Jackson Hilton.

JOHN HEY of Greenwood is the new president of the Leflore County Heart Association. GEORGE NASSAR and JOHN WOFFORD are the medical representatives.

DONALD T. IMRIE of Vicksburg attended a meeting on juvenile arthritis and other arthropathies in children in Houston, Tex.

CECIL JENKINS of Jackson is currently serving as president of the Millsaps College Alumni Association Board of Directors.

MYRON W. LOCKEY of Jackson and UMC attended the centennial conference on laryngeal cancer at the University of Toronto in Ontario, Canada.

GEORGE H. MARTIN of Vicksburg has been named to the board of directors of First National Bank of Vicksburg.

A. J. MARTINOLICH of Bay St. Louis was appointed by the Waveland mayor and board of aldermen to serve on the Gulf Coast Health Resources Council.

GARLAND E. MCCARTY has associated with the Hattiesburg Clinic Professional Association for the practice of neurology and electroencephalography.

ELLIS M. MOFFITT of Jackson represented internists in Mississippi at the 18th annual meeting of the American Society of Internal Medicine in San Francisco in May. Dr. Moffit is president of the Mississippi Society of Internal Medicine.

WALTER R. NEILL of Jackson addressed the medical staff of Mercy Regional Medical Center in Vicksburg on the subject of stroke.

NORMAN C. NELSON, JAMES C. HAYS and T. D. LAMPTON, all of Jackson, presented a MHA educational program on high blood pressure to Jackson business leaders during high blood pressure month in May.

JOHN PEARSON of Hattiesburg was guest speaker at the District 10 Mississippi Heart Association annual meeting.

LAMAR PURYEAR of Hazlehurst has been appointed clinical instructor in community medicine at Tulane University School of Medicine in New Orleans.

DONALD M. SHERLINE of Jackson and UMC met with the National Academy of Sciences steering committee in Washington, D. C., in May.

SAMUEL J. SIMMONS, III, announces the relocation of the Internal Medicine Clinic to Physicians Mall, 4601 Hospital Road in Pascagoula.

GEORGE V. SMITH of Jackson and UMC presented a paper at the Society for Surgery of the Alimentary Tract, Inc., meeting in San Francisco.

J. TATE THIGPEN of Jackson and UMC attended the Southwest Oncology Group meeting in Kansas City, June 4-7.

DAVID H. THORNHILL of Gloster was presented the Chamber of Commerce Outstanding Citizen Award at the annual banquet.

WALTER TREADWELL of Jackson has been elected vice chairman of the Hinds-Madison-Rankin chapter advisory board to the Mississippi Lung Association. G. BOYD SHAW of Jackson is on the board also.

NEY WILLIAMS of Jackson spoke on "The Battle of Raymond" at the monthly meeting of the Jackson Civil War Roundtable. Dr. Williams is a member of the board of directors of JCWRT.

M. J. WOLFE, SR., of Bay St. Louis was honored by the staff and administrators of Hancock General Hospital as part of the local observance of National Hospital Week. Dr. Wolfe has been practicing medicine for 41 years and is currently serving as chief of staff.

Dr. Senter Is Mid-South President-elect

Dr. Jack M. Senter of Belmont is the new president-elect of the Mid-South Medical Association. He was elected at the eighty-third annual meeting in Memphis.

Dr. Senter has been practicing family medicine in Belmont for the past 22 years. He has served as president of the Northeast Medical Society and is also a member of MSMA and the AMA.

He received his M.D. degree from Southwestern Medical College in Dallas in 1949 and completed internship at City-County Hospital in Ft. Worth.

UMC Nurse Education Building Is Renamed

The Nurse Education Building at the University of Mississippi Medical Center has been renamed the Christine Louise Oglevee Building.

Announced on the 25th anniversary of her appointment to head the state's first college level nurse education program, the name change honors Miss Christine Oglevee, dean of the School of Nursing. She is scheduled to become dean emeritus July 1 but will remain with the school as a consultant until she reaches retirement age.

Miss Oglevee was appointed to head the then nursing department at Ole Miss on May 17, 1949, shortly after the Legislature authorized the department's creation.

SCHEDULE FOR UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by the Network for Continuing Medical Education (NCME):

July 15-Aug. 11

Snakebite, with Findlay E. Russell, M.D., Professor of Neurology and Director, Laboratory of Neurological Research, University of Southern California School of Medicine, Los Angeles.

Skin Testing for TB, with John A. Crocco, M.D., Director of Pulmonary Disease Section, St. Vincent's Hospital and Medical Center, New York, and Downstate Medical Center, Brooklyn.

Parasitic Infestation: Look for Lice, with Silas E. O'Quinn, M.D., Professor of Dermatology and Dean of Medicine; and Harold Trapido, Ph.D., Professor of Tropical Medicine and Medical Parasitology, both at Louisiana State University School of Medicine, New Orleans.

Aug. 12-Sept. 8

Receptor Drugs: Time Borrowers in Shock, with Leon I. Goldberg, M.D., Professor of Medicine and Pharmacology, Director of Clinical Pharmacology, Emory University School of Medicine, Atlanta.

Local Anesthesia: Three Effective Techniques, with William C. North, M.D., Professor and Chairman, Department of Anesthesiology, University of Tennessee, Memphis.

The Problem Pelvic, with Philip Sarrel, M.D., Associate Professor of Obstetrics and Gynecology, Yale University Medical School, New Haven.

For more information about NCME, write the Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

(Program scheduling subject to change)

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, Miss. 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white bond paper with a standard typewriter.

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10, but when justified to the Editors, additional references will be considered for publication. Each will be critically examined, and only valid, primary references will be published. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made after proof sheets are received by the JOURNAL.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for illustration engravings not exceeding four column inches per printed page.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript separately from the text.

Reprints may be obtained at cost plus shipping charges from the association and should be ordered prior to publication. The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

Book Review

Current Pediatric Diagnosis and Treatment. 3rd Edition. By C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brian, M.D. 1020 pages with illustrations. Los Altos, Calif.: Lange Medical Publications, 1974. $12.00.

This is the third edition of this pediatric text. Again the authors emphasize the more common pediatric disease syndromes with a very practical aspect of treatment. There are major revisions of the sections on neonatology, the respiratory tract, cardiology, hereditary diseases, ENT, ambulatory pediatrics and nutrition.

Each section is authored by an authority in the respective fields of pediatrics.

The binding is flexible and there are 1020 pages.

Dr. Silver has the opening chapter on History and Physical Examination of the Child. The questions which are pertinent in taking a history are reviewed, and to a neophyte would represent a must to commit to memory. Beneath each subtitle of area of examination, a practical note is given. These are extremely helpful and could only be derived from years of observation and practice. Example: Under the sub-title *Skin Practical Note:* Loss of turgor of calf muscles and skin over abdomen is evidence of dehydration. The chapter on Growth and Development should be periodically re-read by all pediatricians since the author gives many practical bedside tips in rapid calculation of normal weight and height for age groups. *Example:* Between the ages of 3 and 12 months the weight of the child in pounds is equal to his age in months plus 11.

He includes all well known weight charts and most useful charts of sexual characteristic growth in male and female. There is a chart of the epiphyseal ossification times, one on dental growth and development, and a chart of speech sounds expected in the infant from one month to eight years. There are simple evaluations of general intelligence of the child with the intelligence being divided in three stages: 1st—Birth-2 years involves sensori-motor operation, 2nd—18 months to 11 years involves concrete operations, 3rd—stage begins with adolescence and the child is able to handle abstract thoughts. This chapter is outstanding and complete.

The chapter on Ambulatory Pediatrics is new and practical topics such as imbedded ticks, imbedded fish hooks, fiberglass itch, torn skin and traumatic tooth avulsion are discussed with definitive treatment given. Flow sheets are given for continued clinic outpatient care.

In the section of Viral and Rickettsial Disease by Dr. Fulginiti, under each disease title, the essentials of diagnosis are listed; also a chart is given for the differential diagnosis of exanthematous diseases.

The essentials of diagnosis and treatment are given for Bacterial and Spirochetal Infection. Details of etiology, disease process and physiology must be found in other more complete texts.

The section on Genetics and Chromosomal disorders was written by Dr. Robinson and Dr. O'Brien and is up-to-date and complete. It would serve as a postgraduate refresher for most practicing pediatricians.

There is a complete list of drug dosages and evaluation of laboratory tests.

The entire text, in my opinion, is most useful and up-to-date. It is a task for a practicing pediatrician to keep up-to-date material at his finger tip. I feel that each pediatrician would benefit from the purchase of this book, which is presented in a useful format and with an unusual number of useful charts.

MARY J. WARD, M.D.
Corinth, Miss.

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First Mississippi Community Hospital CME Program Is Accredited

The Council on Medical Education of the Mississippi State Medical Association approved accreditation for the Mercy Regional Medical Center's continuing medical education program this past May 24, 1974. Accreditation of this newly developed program is for one year and extends from the day of the survey.

The meaning of this initial survey is twofold. The Mississippi State Medical Association, through its Council on Medical Education, has taken an active role in support of continuing medical education at the local level. In addition, physicians at the community hospital level may now receive credit for the hours spent in organized continuing medical education. This will be especially attractive to the medical staff of Mercy Regional Medical Center and the surrounding community hospitals. Physicians, over a period of years, will be able to earn adequate credit hours of continuing medical education to apply for the American Medical Association's Physician Recognition Award, as well as earn hours toward the AAFP stipulated CME hours.

To further the much needed activity of continuing medical education in the community hospital, the Council on Medical Education is planning to survey additional hospitals and recommend a form of accreditation.



Dr. Charles N. Floyd (at left) serves as chairman of the first continuing medical education survey team which met with Clifton Watson, G. M. Rankin, M.D. (right) and other members of the Mercy Regional Medical Center staff. Working with Dr. Floyd on the survey team were T. D. Lampton, M.D., and M. S. Costilow, M.D.



Dr. Rutledge W. Howard (left) represented the American Medical Association during the first CME survey conducted by the Mississippi State Medical Association. During the past year, Dr. Howard has counseled with staff members of the association in preparation for this first survey. Dr. John R. Shell is a member of the Education Committee of Mercy Regional Medical Center and here he is shown discussing medical data presented during a CME course the day of the survey.

Medical Center Graduates 92 M.D.s

Ninety-two medical students—the largest class ever—got the M.D. when Chancellor Porter L. Fortune conferred degrees on University of Mississippi Medical Center graduates in May 26 commencement ceremonies.

Graduates for the 1973-74 session also included 41 students who received the B.S. in Nursing, seven the Ph.D., 11 the master's in a health science, and 13 the master's in nursing.

University Chancellor Emeritus J. D. Williams, speaker for the ceremony, traced the Medical Center's early development and said that during its brief history "growth and achievement have been better than its planners ever dreamed."

Dr. Williams said measuring UMC accomplishments in terms of money invested, patients served, grants received, and the 2340 degrees and certificates awarded since 1957 is necessary and important; but so is "the measure of the quality of service" to state health care.

He cited the center's close cooperation with local public health clinics, its role in preparing nurses for expanded roles on their community health teams, and its efforts to give professional students early exposure to local health care through field training experiences as examples of UMC services which can qualitatively affect medical care in Mississippi.



Vice Chancellor for Health Affairs Dr. Norman C. Nelson congratulates top graduates at the University of Mississippi Medical Center 18th commencement. Dr. Richard Evans Weddle of Eupora, center, received the Waller S. Leathers Award as the graduating senior with the highest academic average, and Dr. William Chandler Cushman of Jackson, right, received his M.D. degree magna cum laude.

Summa cum laude graduate Richard Evans Weddle of Eupora received the University's Leathers Award as the graduating medical student with the highest academic average.

Other honor medical graduates included Mervyn Percy Smith, Jr., of Clinton and William Chandler Cushman of Jackson, both of whom earned their degrees magna cum laude, and William Roderick Marshall of Gulfport, Charles Weinacker Montgomery of Yazoo City, Thomas George Brewer of Leland and Doyle Frazier Sumrall of Biloxi, who graduated cum laude.

Dr. R. P. White Heads Mental Health Dept.

Dr. Reginald P. White of Meridian will head the new state Department of Mental Health. Dr. White was selected by the department's governing board shortly after the board was appointed by Governor Bill Waller.

Dr. White has been director of East Mississippi State Hospital in Meridian since 1964. Prior to that appointment, he was senior psychiatrist and director of outpatient services at Mississippi State Hospital at Whitfield.

Dr. White earned his M.D. degree from the University of Tennessee and interned at St. Joseph Hospital in Memphis. He completed a psychiatry residency at Mississippi State Hospital and the University of Louisville.

He was certified by the American Board of Psychiatry and Neuropsychiatry in 1962. The psychiatrist is a member of AMA, MSMA, and a Fellow of the American Psychiatric Association. He has served as president of the Mississippi Psychiatric Association and was secretary of the East Mississippi Medical Society 1967-1974.

Among the many honors he has received are the 1972 MSMA-Robins Award for outstanding community service by a physician and the Liberty Bell Award for outstanding community service.

The new department, which by statute comes into existence July 1, will inherit the mental health funds and consolidate services of three existing mental health agencies: The State Board of Health, Board of Mental Institutions, and the Interagency Commission on Mental Health and Mental Retardation.

Dr. Jerry Hopkins of Oxford was named temporary chairman of the board. Appointed to the panel also were Dr. Duane Burgess of Hattiesburg;

Mrs. Tommy Hale of Pontotoc; Eugene McLemore of Greenville; J. C. Williamson of Philadelphia; Seth Hudspeth of Jackson; and A. B. Albritton, Jr., of Gulfport.

Heart Association Holds Annual Assembly



Dr. William L. Wood, Jr. of Tupelo, President of Mississippi Heart Association, demonstrates cardiopulmonary resuscitation to other officers of the association. They are (left to right): Charles W. Holt of Hattiesburg, President-Elect; Ernest G. Spivey of Jackson, Treasurer; Dr. Wood; Senator W. B. Alexander of Cleveland, Secretary; and Dr. L. Gerald Hopkins of Oxford, Vice President. These new officials took office the organization's Annual Assembly held at the Jackson Hilton.

Surgeons Slate Meet for Miami

The world's largest meeting of surgeons, the 60th annual Clinical Congress of the American College of Surgeons, will be held in Miami Beach, Fla., Oct. 21-25.

The meeting will be the first to be held in the newly-expanded Miami Beach Convention Center now nearing completion.

Close to 20,000 surgeons, guests, and members of other medical professions are expected to attend the congress.

The Clinical Congress Program will include:

(1) 17 postgraduate courses. The American College of Surgeons has been accredited for its continuing education programs by the American Medical Association. Each hour of the program is equivalent to one hour of Category 1 credit toward the AMA Physician's Recognition Award.

(2) More than 260 research-in-progress reports called the Forum on Fundamental Surgical Problems.

(3) More than 50 panel discussions and symposia on general surgery and the surgical specialties.

(4) Live telecasts of operations originating from Jackson Memorial Hospital, Miami.

(5) More than 130 films and Ciné Clinics, including those in "spectacular surgery."

(6) A wrap-up of "What's New in Surgery."

(7) More than 350 scientific and industrial exhibits.

(8) Major addresses by the president of the college and a roster of eminent guest speakers.

(9) Presentation of the college's Distinguished Service Award to an outstanding Fellow on Thursday, Oct. 24, at the annual meeting of Fellows.

(10) Convocation ceremonies for initiates inducted into fellowship (membership) in the college on Thursday, Oct. 24. Fellowship is awarded to those surgeons who have fulfilled comprehensive requirements of acceptable medical education and advanced training in surgery or one of its specialties, and who have given concrete evidence of high competence in their field, good moral character and ethical practice. Honorary Fellowships will be awarded to distinguished international scholars in the same ceremonies.

A pre-Clinical Congress course in Scientific Communications designed to improve competence of scientists in self-expression through writing and speaking will be held Oct. 19 and 20 in the Doral Beach Hotel, Miami Beach. There is a separate $100 fee for this course. A special registration form is available from the college's Communications Department.

Registration is free for Fellows of the college whose dues are paid to December 1973; initiates; members of the Candidate Group; and surgical residents. Non-Fellows pay $90. Non-Fellow physicians in the Federal Service pay $50. Everyone who enrolls in one of the 17 postgraduate courses, including those who register free, must pay the fee for the course selected.

Study Group Criticizes Acupuncture Misuse

The head of the federal government's acupuncture study committee has stated that there is no scientific evidence at this time that acupuncture will actually *cure* anything.

And he lashed out vigorously at "unscrupulous persons exploiting the public's interest" in acupuncture through operation of treatment centers.

Furthermore, promiscuous use of acupuncture in an effort to cure a wide variety of ailments can be dangerous, says Dr. John J. Bonica. Needles break off in the patient. Vital internal organs are punctured. And, most serious, a reliance on acupuncture treatment may delay start of proper medical therapy until it's too late.

The report is in the June 17 issue of the *Journal of the American Medical Association,* titled: "Therapeutic Acupuncture in the People's Republic of China: Implications for American Medicine."

The report deals primarily with use of acupuncture to treat disease, rather than its function to relieve pain.

Dr. Bonica, called by an accompanying *JAMA* editorial "one of the great students of the phenomenon of pain," is chairman of the Department of Anesthesiology at the University of Washington, Seattle. He also is chairman of the Ad Hoc Committee on Acupuncture of the National Institutes of Health and the American Society of Anesthesiologists.

Dr. Bonica's lengthy and detailed study of acupuncture draws four major conclusions:

- The misuse of acupuncture to try to cure disease is an important health problem.
- The widespread use of acupuncture to try to cure disease is unwarranted at the present time.
- Since relief of pain and response to treatment are influenced by many factors, including culture, tradition, education, background and genetic factors, and because acupuncture is a new therapeutic factor in American medicine, it is essential that it be tested in American patients using well-established scientific principles.
- Each state should legislate to permit such studies to be carried out until sufficient data are available to ascertain if acupuncture is better than, as good as, or inferior to well-tested drugs and procedures.

Tri-State Heart Sessions Held



A three day seminar entitled "Controversies in Cardiology" was held in Biloxi during May. Program participants included (from left) Dr. John Collins, Jr., of Boston, Dr. W. H. Rosenblatt of Jackson, American Heart Association President Dr. Richard S. Ross of Baltimore, Dr. M. Leonard Dreifus of Philadelphia and Dr. Alberto Benchimol of Phoenix. Over 100 doctors from the three state area attended the sessions which were sponsored by the Mississippi, Louisiana, Arkansas and American heart associations.

Dr. Jonathan Rhoads Speaks at UMC



Dr. Jonathan E. Rhoads, second right, professor of surgery at the University of Pennsylvania School of Medicine, was Alpha Omega Alpha guest speaker at the University of Mississippi Medical Center Honors Day. Talking with the distinguished medical educator are, from left, Vice Chancellor Norman C. Nelson and senior medical students Rodney Meeks of Jackson and Dick Smith of Clinton.

Association Prepares for Summer Months



MSMA Executive Secretary Charles L. Mathews is shown with grounds supervisor Jessie Taylor as they prepare to "initiate" a new mower for the association's office grounds on Riverside Drive. Jessie is 73 and has been with the association for 12 years.

CME Program Aims at Atherosclerosis

Nineteen medical, nutritional and biochemical experts have collaborated to produce a new physicians education program to help doctors treat and prevent coronary heart disease (CHD).

Called ATHEROSCLEROSIS, the learning system brings together the most current experimental and epidemiologic work in the field. The complete program consists of a 30-minute color teaching film, an 80-page color monograph and a self-evaluation section designed to help physicians test how much they've learned.

The program has been accredited by the American Academy of Family Physicians for three hours of Continuing Medical Education credit.

It was developed with funds from the Best Foods Division of CPC International, the first food manufacturer to sponsor such an effort. It is available free to medical schools, hospital staffs, medical associations and practicing physicians through MEDCOM, Inc., a leader in medical education programs.

"ATHEROSCLEROSIS provides physicians and physicians-to-be with the up-to-date information they need to properly manage coronary heart disease patients and help healthy patients minimize the risk of heart disease," Dr. David Lauler, chairman of MEDCOM's Department of Medicine, said.

"The program answers questions about lipid levels, serum cholesterol, arterial damage, diet and other vital factors affecting atherosclerosis through multimedia techniques that stimulate the physicians' involvement."

The monograph contains 11 chapters, each written by one or more experts. There is also an extensive bibliography and a provocative editorial by editor Dr. Frederick J. Stare, chairman of the Department of Nutrition at Harvard University's School of Public Health. In his editorial Dr. Stare challenges the medical community:

> "We all know premature heart disease is epidemic in this country, yet why are we physicians so slow to take action against severe atherosclerosis and its complications when there is abundant evidence of the relationship between cholesterol and CHD"

Dr. Stare then suggests that we must prevent atherosclerosis early in life by changing diet and living habits.

The monograph describes in detail the statistical validity of Dr. Stare's premise and discusses the chemistry of lipids—the first step in understanding atherosclerosis. Other chapters profile blood lipids and explain how to manage adult hyperlipidemia.

Advice on how to lower a patient's cholesterol level as well as some straight talk on food oils and how to use them is also included. Finally, several medical experts give their own advice on cutting the risk of CHD.

The monograph is filled with interesting color pictures, charts and graphs which convey in dynamic terms the subject covered by each expert.

Physicians wishing to schedule the learning system for local medical groups should contact Dr. David Lauler, MEDCOM, Inc., 2 Hammarskjold Plaza, New York, N.Y. 10017

UMC Resident Receives SMA Grant

Dr. Thomas A. Polk, resident physician at the University of Mississippi School of Medicine, Jackson, Miss., has been named recipient of a Southern Medical Association (SMA) residency training grant.

The SMA executive office in Birmingham, Ala., reported that Dr. Polk was one of nine physicians selected for the grants from throughout the organization's territory of 16 southern states and the District of Columbia. Each year SMA awards grants and loans to enable physicians to continue their residency training.

The Residency Training Grant and Loan program was established in 1962 as part of SMA's continuing effort to develop and foster scientific medicine.

The 22,000-member physician group will hold its 68th Annual Scientific Meeting, the second largest conclave of scientific medicine in the nation, in Atlanta Nov. 17-20.

JAMA Features Handling Difficult Patients

What does the doctor do when his patient fails to follow the doctor's directions for getting well and staying well?

Should he just charge off the patient as an "uncooperative personality," or should he keep trying to persuade the patient to do what he should?

By all means, the doctor should keep trying, says a communication in the June 17 issue of the *Journal of the American Association.* In fact, patient noncompliance is in itself a serious medical problem that deserves much more attention from the medical profession, say Drs. Richard F. Gillum and Arthur J. Barsky. Dr. Gillum is with the National Heart and Lung Institute, Bethesda, Md., and Dr. Barsky is with Massachusetts General Hospital, Boston.

"Patient noncompliance with medical regimens drastically curtails the benefits that could accrue to patients from therapeutic regimens, produces inestimable costs, both economic and human, and provides considerable frustration for physicians," the authors write.

"The magnitude of the problem is evident when one considers that at least a third of the patients in most studies failed to comply with doctors' orders," and that in some of the studies as many as half did not comply.

Drs. Gillum and Barsky urge their fellow physicians to attack the problem of noncompliance from the standpoint of four factors that have been found to be at cause—Psychological factors; Environmental and social factors; The therapeutic regimen, and The physician-patient relationship.

Those who resist medical directions for psychological reasons often are individuals who perceive themselves as less susceptible to and threatened by actual or potential illness. They tell themselves—It won't happen to me.

Among environmental and social factors involved, poverty and unemployment are high. Lack of money, lack of transportation, family problems at home all contribute to neglect of the doctor's orders. Social agencies often can help with these problems.

A realistic therapeutic regimen that does not entail too drastic a change in life style will work better than a hard-nosed admonition to quit smoking and lose 30 pounds. Physician-patient interaction simply means that the doctor should take the time to establish a friendly rapport with his patient, so that the patient will do what the doctor orders.

It is important for the doctor to educate the patient as to the exact physical condition and the sound reasons behind his instructions, they say.

Medical Schools Can Desensitize Students

Many of the experiences encountered by the medical student during his early training can lead to a "desensitization" concerning the more human aspects of medical practice, a researcher says in a recent issue of *News & Comment,* the monthly membership publication of the American Academy of Pediatrics.

Dr. Chase Patterson Kimball, an Associate Professor in the Departments of Psychiatry and Medicine at the University of Chicago, was interviewed concerning a study he and colleagues are undertaking with medical students at Yale University and the University of Chicago.

The study, based on questionnaires and in-depth interviews with the students as they progress through their medical training, is nearly two years old. Statistics on the findings are far from complete, but Kimball said some common trends have been identified.

He said students generally become increasingly cynical during their first two years in medical school, and this attitude persists into their years as residents.

Possible reasons for such a reaction, Kimball said, include: the general shock of entering any profession; the lack of physician "models" for the student to identify with during his early training;

and the lack of "patient orientation" in the medical school curriculum.

Kimball said the student passes through several "nodal points" during his early training, experiences with potentially upsetting consequences. One of these, he said, was the first confrontation with the cadaver.

"In this one act," Kimball said in the interview, "the student has overcome thousands of years of taboo in terms of dissecting or desecrating another human form. And, instead of bringing this up for discussion, or talking about the emotions . . . that are generated by this experience, the time-honored fashion for medical students is to bear it and grin or make humorous comments about it. This in itself tends to set the model of denying the emotions that are related to such an experience."

Kimball said medical schools should rely less on undergraduate grade averages in the sciences when choosing applicants for training. He also suggested modifying the medical school curriculum, offering students earlier exposure to patients, earlier emphasis on the psychological and social aspects of illness, and earlier interaction with physician "models."

Kimball said students complained in the study's interviews about the heavy work load, alienation from teachers and other students, and the passivity of early training in the classroom.

"I think medical schools have not changed as quickly as medicine has," Kimball said. "The emphasis in medicine today is much more on prevention, on approaching problems that are not always pathophysiological in scope.

"Yet, we don't convey that model in medical school, partly because there is only a limited time to teach, partly because the tradition has been set largely in terms of a pathophysiological approach to disease. I don't think our medical schools have made that transition in looking at these other aspects of illness."

SBH Announces Change in Rabies Quarantine

Any person bitten by a dog or cat has always been advised to quarantine the animal for 10 days. If the animal remains well for that period of time, there is no risk of rabies transmission to the person bitten.

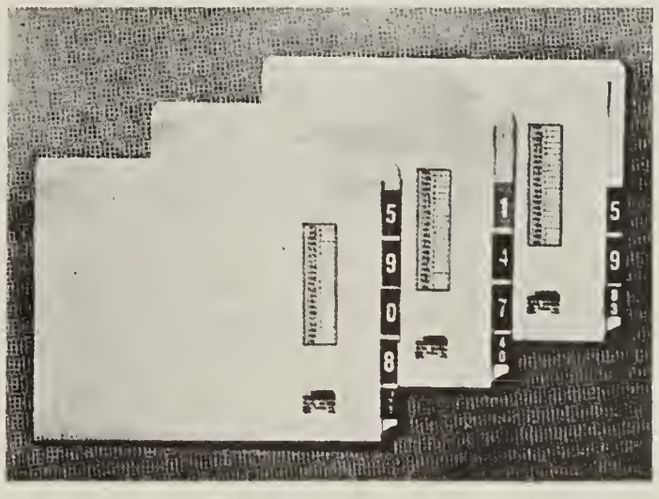
A new alternative to this procedure has been announced by the World Health Organization, according to Dr. Durward Blakey, Director of the State Board of Health Bureau of Disease Control. The WHO announcement is as follows:

> "The Committee suggests that *under certain circumstances* unvaccinated dogs that bite without provocation may be killed for immediate examination by the fluorescent antibody (FA) technique, in order to avoid human treatment if the brain is negative. The decision to adopt this course should be conditional on the following considerations: (a) The presence of rabies in the area; (b) The agreement of health authorities and the dog owner to kill the dog; (c) The presence of a reliable rabies diagnostic laboratory with fluorescent microscopy facilities."

You should be reassured that the FA technique is as sensitive a test as animal inoculation and will detect any rabies positive specimens. Further, no animal is known to have virus present in the salivary gland or other tissues prior to its being in the brain.

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Breast self-examination:

KEY ROLE OF THE PHYSICIAN

item:	**Breast cancer is a major concern of American women, according to a recent Gallup study conducted for the American Cancer Society.**
item:	**Although aware that early discovery improves the chances of cure, and that BSE can lead to early discovery, *fewer than 1 in 5* women practice BSE, and *only half* have an annual breast examination by a physician.**
item:	**Only 35% of all women polled reported that a *physician* had ever raised the subject of breast self-examination, and only 24% had received instruction from the physician on how to do it. Even among women who regularly see a gynecologist, only 34% had been instructed on BSE.**
item:	***But,* among women who received personal instruction from their physicians, the overwhelming majority *(92%)* practiced BSE during the preceding year.**

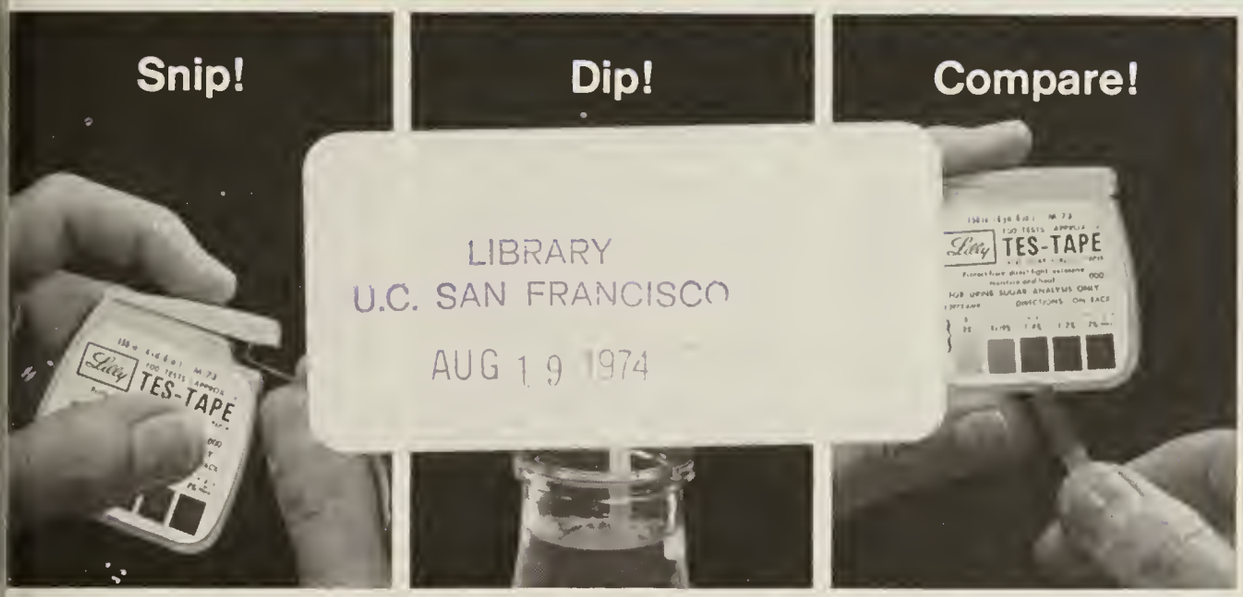
The Gallup study revealed that, far more important than increasing awareness of breast self-examination, is the problem of inducing women to practice it regularly. The physician plays a key role in this—by teaching women the correct technique, and instilling in them the confidence that will assure their continued practice of BSE.

The American Cancer Society gives major emphasis to breast cancer through research and a vast array of public educational materials, designed to give women life-saving information about the disease. Our latest approach is via a pioneering television film starring Jennifer O'Neill, "Breast Cancer: Where We Are." Where we *will* be in a few years will certainly hinge on our joint efforts.

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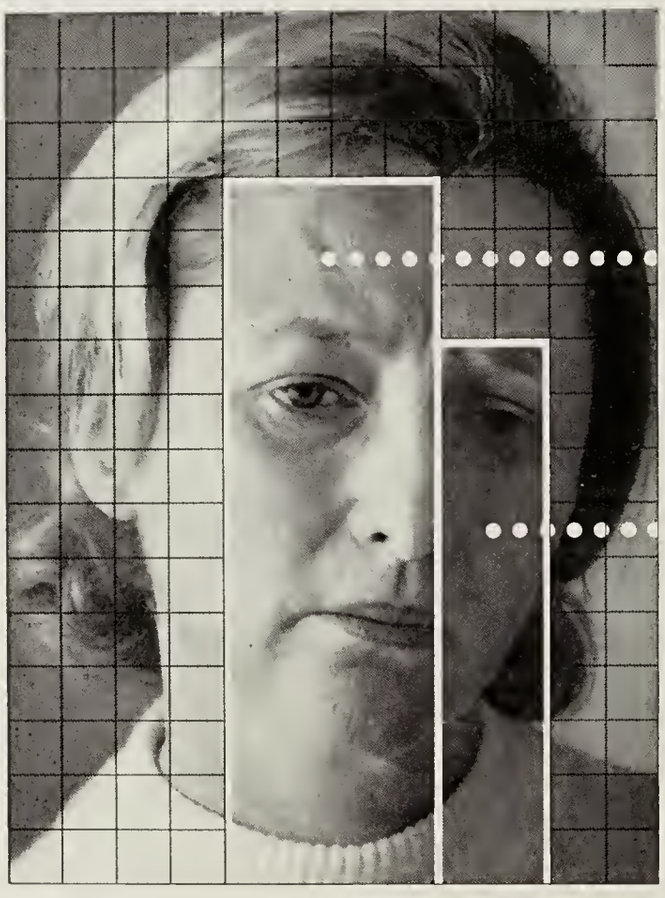
This Month . . . Neuropathology,

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August 1974



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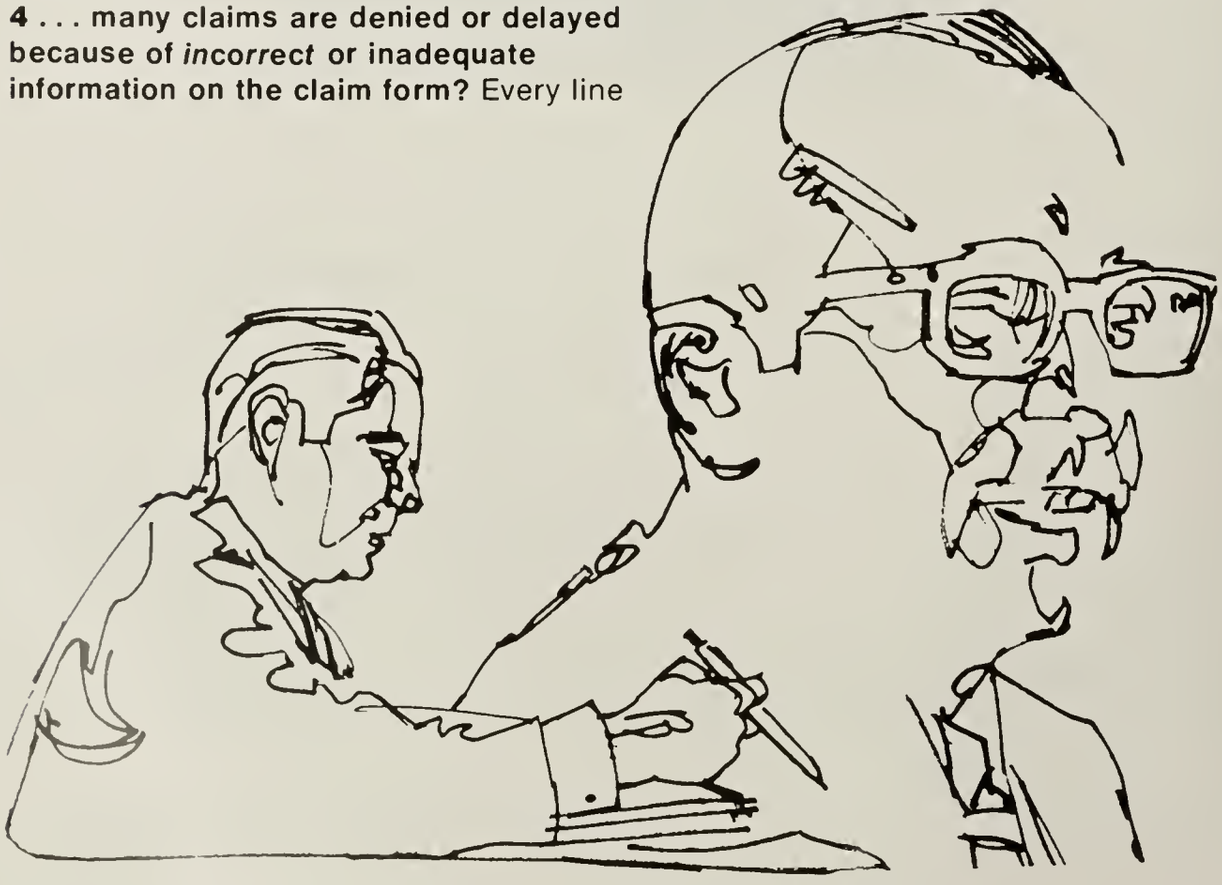
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ORIGINAL PAPERS

Seminar in Neuropathology: Part III

J. BEBIN, M.D., Ph.D.
Jackson, Mississippi

PRIMARY FIBROSARCOMA OF THE BRAIN

Case No. 5: A 42-year-old man was admitted to the hospital with a history of easy fatigability, weakness and weight loss of two months duration. In addition he had a low grade fever and leukocytosis of 24,100. On examination, the patient was lethargic and showed a left facial weakness, left hemiparesis, left homonymous hemianopsia, left tactile extension, astereognosis and apraxia on left hand. The fundi were normal and the general physical examination was within normal limits.

A right carotid arteriogram showed a shift of the right anterior cerebral artery to the left with elevation and medial displacement of the right middle cerebral artery. On the same day a right fronto-temporal craniotomy was performed with removal of 115 grams of a "hard, firm" neoplasm. One month later the patient was discharged from the hospital but was readmitted three weeks later because of right sided headaches and increasing weakness on his left side. On this admission he was well oriented but obtunded. There was no papilledema. He showed a left facial weakness, increased tendon reflexes, extensor plantar response on the left and a complete left homonymous hemianopsia. A new right carotid arteriogram showed increased displacement of the right middle cerebral artery. A right fronto-temporo-parietal craniotomy was done and removal of 70 grams of a neoplasm was carried out. One week later the patient had a third craniotomy and 42 grams of tumor were removed from the right temporal region. Following this the patient's course was one of gradual deterioration with an increasing bulging mass in the operative site. He expired three weeks later.

Cases 5 and 6 of the Seminar in Neuropathology are featured in Part III. The author discusses primary fibrosarcoma of the brain and germinoma giving case histories to illustrate both. Parts I and II of the seminar were published in the June and July issues, respectively.

An autopsy revealed a large tumor, measuring 8.5 × 5 × 7 cm, in the right temporal lobe. The tumor was firm and lobulated. On sectioning, it contained extensive areas of hemorrhage and necrosis. Other findings were bronchopneumonia and generalized arteriosclerosis. No other neoplasm was encountered.

In this patient with a rapidly recurrent brain tumor, the significant information is that at the first operation 115 grams of tumor were removed; a few weeks later another 70 grams of tumor were removed; and another 42 grams at a third operation. This means that it was a rapidly growing neoplasm.

At autopsy a large tumor, 7 × 8 × 5 cm, was found in the right temporo-occipital region. The tumor appeared firm, lobulated and well circumscribed, although a capsule was not evident.

The following figures 7, 8, and 9, illustrate the histologic appearance of this tumor. Sections were

Presented at the Tri-State (Ala.-La.-Miss.) Pathology Meeting, Jan. 29, 1974, Biloxi, Miss.
From the Department of Pathology, University of Mississippi School of Medicine, Jackson, Miss.

made both from the biopsy material and from the autopsy material. They showed no significant differences and they will be described together as a composite picture. The neoplasm is extremely cellular, composed of streams of spindle-shaped cells running in various directions. These cells have an eosinophilic cytoplasm with an oval or elongated nucleus, well defined nuclear membrane, dusty chromatin, and one or two prominent nucleoli. Scattered throughout the neoplasm are numerous atypical and multinucleate giant cells of bizarre and irregular shape. In the nuclei of some of these cells, eosinophilic inclusion-like bodies and vacuoles could occasionally be seen. Atypical mitoses were abundant throughout. Special stains showed no Nissl bodies in cytoplasm of the neoplastic cells. No cross or longitudinal striations were seen in the multiple sections studied. The blood vessels were abundant and prominent; many of them exhibited thickened walls and some endothelial hyperplasia. The stroma contained abundant collagen and reticulin fibers. In addition, areas of necrosis and hemorrhage were present throughout the neoplasm.

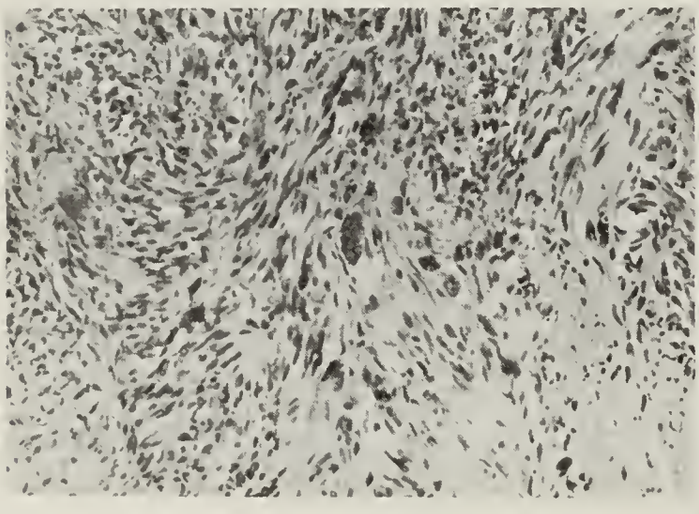


Figure 7. Case No. 5: A low magnification view shows the intersecting fibrosarcoma elements. H & E × 150.

In summary, the important characteristics of this neoplasm are: (1) its origin in the intracranial cavity (no other tumor was found at autopsy), and (2) a malignant neoplasm made up of rapidly proliferating cells of fibroblastic type with presence of numerous atypical giant cells and mitoses.

This tumor resembles very much the fibrosarcomas of the dura mater and I think the most appropriate designation for it is "primary fibrosarcoma of the brain." Its origin is controversial. It may arise from elements of the meninges accompanying the penetrating vessels into the brain, from the dura mater, or from the connective tissue of the blood vessels within the brain.



Figure 8. Case No. 5: Shows the abundant reticulin and collagen fibers throughout a fibrosarcoma. Silver stain for reticulin × 150.

In the differential diagnosis, two other neoplasms merit careful consideration. (1) An extremely rare variety of rhabdomyosarcoma, primary in the brain. Regardless of the similarities between these two neoplasms, cross and longitudinal striations were absent in this tumor as well as other cytologic characteristics of rhabdomyosarcomas (vacuolated spider cells, strap and ribbon-like cells). (2) The so-called giant-cell glioblastoma (D. S. Russell and Rubinstein) in which the giant cells dominate the histologic picture and the cells have coarse cytoplasmic processes, very abundant blood vessels, sometimes of angiomatous appearance, and transitional areas of unequivocal glioblastoma. These tumors, although microscopically circumscribed, tend to infiltrate the adjacent brain and the regional leptomeninges. A malignant neuroglial reaction or malignant transformation of a reactive gliosis, although extremely uncommon, is the source of a mixed neoplasm: gliosarcoma.

There is lack of uniformity in the identification and classification of primary sarcomas of the CNS (Rubinstein). These tumors are rare, and great differences of opinion and criteria exist as to what constitutes a sarcomatous tumor in the CNS. They may arise from connective tissue cells of the dura mater, leptomeninges or their pial extension into the brain along periadventitial spaces and stroma of choroid plexus.

Rubinstein excludes the reticulum-cell sarcomas and monstro-cellular sarcoma of Zulch (a variant of

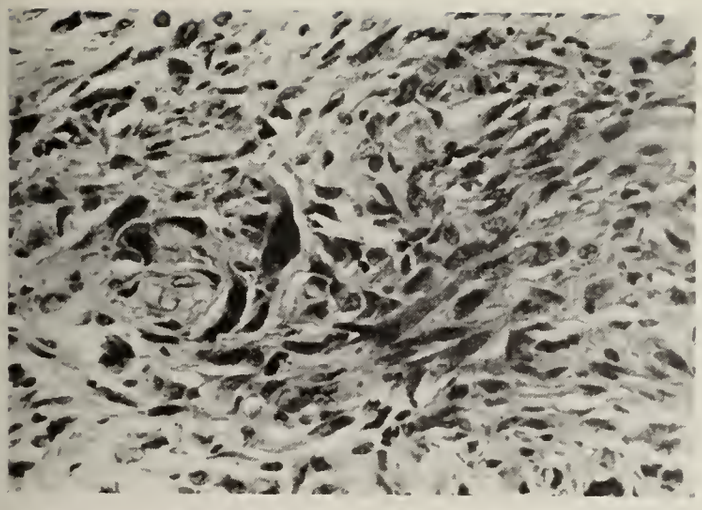


Figure 9. Case No. 5: Higher magnification view shows the "atypical" giant cells and mitotic figures in a fibrosarcoma. H & E × 400.

glioblastoma) from sarcomas of the brain. He includes the following subgroups: fibrosarcoma, spindle-cell sarcoma, polymorphic cell sarcoma, meningeal sarcomatosis, myxosarcoma, chondrosarcoma, embryonal sarcoma.

Their incidence is approximately 3 per cent of all intracranial neoplasms (Kernohan et al). Among patients at the Mayo Clinic, 240 sarcoma cases occurred in 8,070 intracranial tumors. They are more common in infants and children than in adults. Their prognosis is unfavorable. The circumscribed examples could be completely excised at surgery. Extracranial metastases are very rare.

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GERMINOMA (ATYPICAL PINEAL TERATOMA, ECTOPIC PINEALOMA)

Case No. 6: A 28-year-old woman was admitted to the hospital with headaches, nausea, vomiting and diminution of vision. She underwent left craniotomy with subtotal removal of a "pituitary tumor." She later received x-ray therapy. One year later, because of progressive visual field defect, nausea and vomiting, she again had a left craniotomy; and no evidence of gross tumor in the sella turica or vicinity was seen. Six months later recurrence of headaches, nausea and vomiting, speech difficulties and paresis of the left hand occurred.

The pertinent findings were: left hemiparesis (face and arm), left homonymous quadrant anopsia and slow speech.

A right brachial arteriogram showed upward and medial displacement of the right middle cerebral artery. A ventriculogram showed a space-occupying lesion of the right posterior parasagittal region with depression and deformity of the ventricular trigone. Right parietal craniotomy was followed by subtotal removal of a parieto-occipital "tumor." Her postoperative course was stormy and she expired on the third postoperative day. An autopsy was performed.

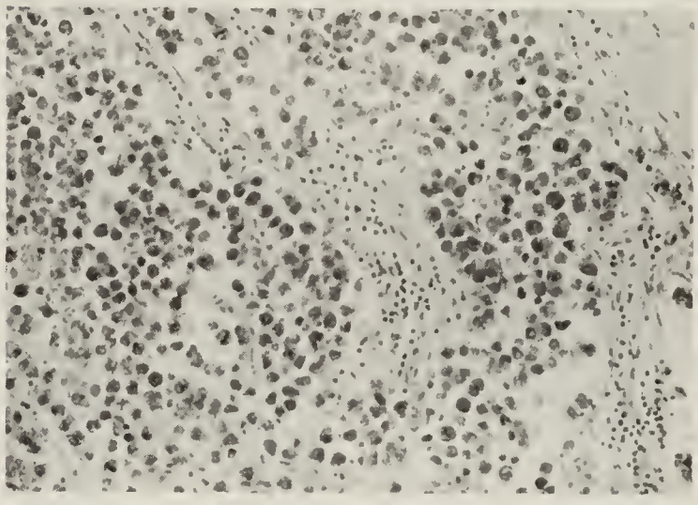


Figure 10. Case No. 6: Typical microscopic appearance of a germinoma showing two cell types: large spheroidal cells with central vesicular nuclei and lymphocytic cells. H & E × 200.

This is the case of a 28-year-old woman who presented features of increased intracranial pressure, loss of vision and loss of some of the hypothalamic and pituitary functions. She was clinically thought to have a pituitary tumor, and underwent a craniotomy and partial excision of a "pituitary neoplasm," following which she had had some relief of symptoms. A year later she had a second craniotomy; at this time, the surgeon found no tumor in the pituitary region. She was discharged and returned to the hospital six months later with right parietal lobe syndrome. She again underwent a craniotomy with the removal of a large tumor. The identity of this tumor (included in the slides for the seminar) and the relationship, if any, between this neoplasm and the first one removed from the sellar region will be the topic of my discussion.

The slides showed the following: first a view of the basal aspect of the brain showing both optic nerves, the left smaller than the right; a bilateral temporal pressure cone, more marked on the right than on the left; and a large neoplasm appearing in the interhemispheric fissure.

The sections of the brain showed considerable edema of the cerebral hemispheres with a partially

hemorrhagic and necrotic neoplasm in the right parieto-occipital region. In addition there was a small tumor nodule beneath the right occipital horn of the lateral ventricle. No other neoplasms were found in the general post-mortem examination.

The neoplasm consisted of cellular masses arranged in islands separated by a vascular connective tissue stroma. Two distinct cell types were present. One was large and spheroidal with granular eosinophilic cytoplasm, devoid of processes and contained a large hyperchromatic nucleus with a prominent nucleolus. The second type, small darkly stained groups of cells resembling lymphocytes, was irregularly distributed in close relation to the vascular connective tissue of the tumor (see figures 10 and 11).

Special stains for glia (PTAH) and Hortega's silver carbonate method (triple variant) revealed no cytoplasmic process (The club-shape endings in the cytoplasmic expansions of pineal cells were absent.). The reticulin fibers were limited to the supporting vascular connective tissue.

The second neoplastic nodule present in the right occipital lobe had similar characteristics to the tumor described. The pineal gland was normal in size and was also normal on histologic examination.

Re-examination of the first biopsy, despite extensive artifacts, showed large spheroidal cells with hyperchromatic nuclei and small deeply stained lymphocytic-like cells, resembling the parietal tumor.

Having established the morphologic identity of these two separate neoplasms, the question remains as to what the relationship is between them. Do they represent examples of a multicentric tumor, or do they represent metastatic tumors?

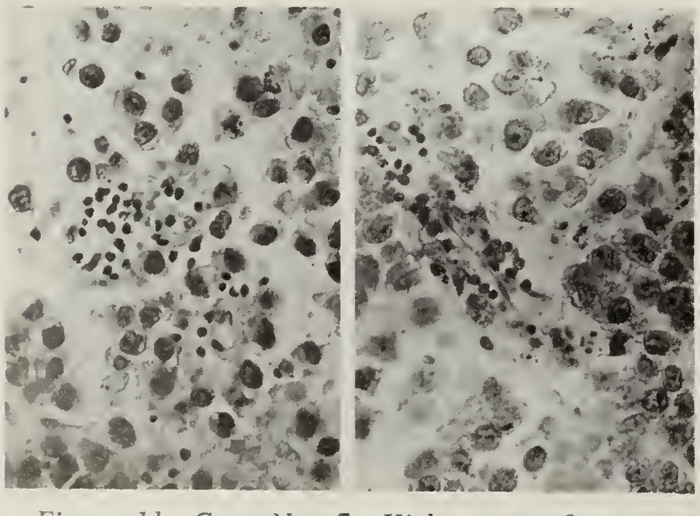


Figure 11. Case No. 7: Higher magnification of Figure 10 showing the characteristic cell types in a germinoma. H & E × 400.

Their histologic characteristics correspond to the so-called "germinomas" (pinealomas) of the ovary or "seminomas" of the testis. This tumor is rare. They arise in the pineal or parapineal region but many are situated elsewhere, "ectopic germinomas." Some of these are in the midline and hypothalamic region, as is the case here.

Germinomas are the most common neoplasms in the region of the pineal body, composing 50 per cent of all tumors in this region. They occur in the second and third decade of life and predominate in males. They originate from primitive germ-cells which migrate over wide areas of the embryo during fetal life. The almost exclusive midline origin of ectopic germinal tumors remains unexplained.

Their microscopic appearance is distinctive, with two types of cells: one large polygonal or spheroidal type with eosinophilic cytoplasm and a spheroidal nucleus with a prominent nucleoli, and small, deeply stained lymphocytic cells distributed along the vascular connective tissue stroma. The fine structure of these tumors is similar to the seminomas of testis and germinomas of the ovary. The pineal and the ectopic germinomas are histologically malignant. They invade and infiltrate neighboring tissues, extend along the walls of the third ventricle, and may spread via the CSF. In 60 per cent of cases reviewed by Dayan et al, spread occurred along the anterior part of the third ventricle. Distant metastases to the lungs have been reported following craniotomy. They are radiosensitive with growth arrests for several years having been reported. It is important to differentiate suprasellar germinomas from lymphocytic infiltrates and reticulum-cell sarcomas.

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Radiologic Seminar CXXXXII: Benign Fibrous Cortical Defects

NANCY W. BURROW, M.D.
Brandon, Mississippi

A FIBROUS CORTICAL defect is not a true neoplasm, but only a localized defect in enchondral bone formation. The presence of these lesions carries no known implication of destructive bone disease nor any relationship to other pathological conditions. The origin of the fibrous tissue filling the defect is believed by most to be of periosteal origin. The sites usually involved are the upper and lower one-third of the long bones, with the medial aspect of the distal shaft of the femur being the most common site.

The cortical defect in the femur can be demonstrated radiographically in a surprisingly high percentage of normal asymptomatic children over three years, but are usually best developed after the sixth year. In most studies it appears that boys account for considerably more than half of the lesions.

During their earliest phase they are small, poorly defined, and located near the end of the shaft. They may extend to the primary zone of calcification, but these defects have not been found in the epiphysis.

The typical appearance of the fibrous cortical defect is a small round ovoid or flame shaped radiolucency seen as a shallow cortical defect. Average sizes range from 1-2 cm, with the long axis of the lesion parallel to the axis of the bone. The margins are well defined and may show as a smooth or scalloped, thin, dense line. A loculated appearance is sometimes seen. They may involve the cortex with a slight localized bulging of the thin cortical plate that remains over the defect.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Rankin General Hospital, Brandon, Miss.



Case I. June 1970. Notice small lesion with well defined sclerotic, scalloped border.

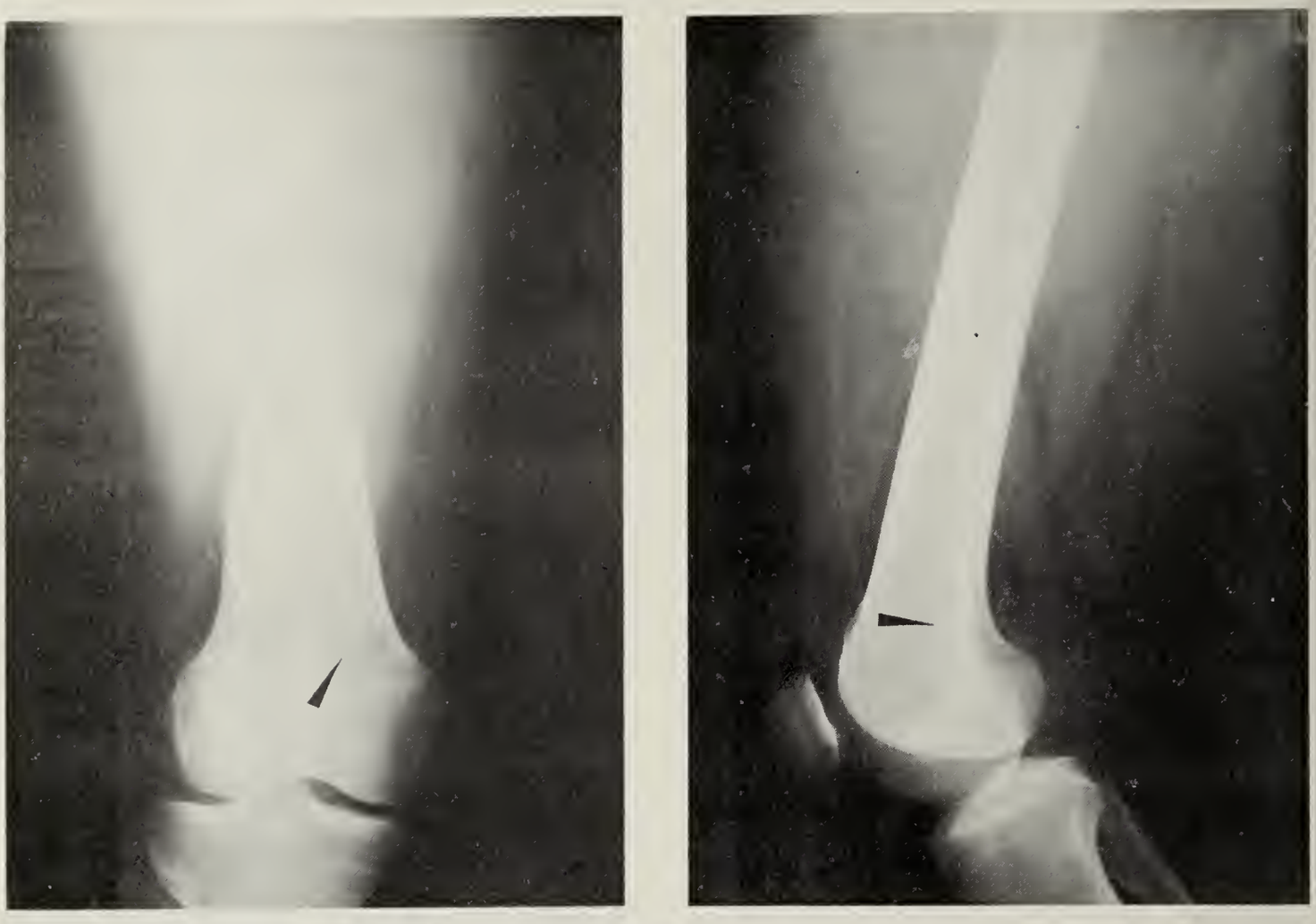
The course of these defects is variable. The majority gradually shift away from the end of the shaft with advancing age and shrink in size until they become invisible. Many gradually become opaque while others persist in the exact site and appearance. Some have been noted to recur from year to year. The larger ones may segment with fluctuations in size and shape. This remarkable liability of the fibrous cortical defect is one of the most characteristic features and one which differentiates it from all the known lesions of growing bone. ★★★

Rankin General Hospital (39042)

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(Please turn to page 332 for more illustrations)



Case I. August 1973. The lesion has healed and become practically invisible leaving only an area of vague increased bone density.



Case II. A large segmental lesion resulting in some thinning and bulging of the cortex over the lesion.

Proceedings of the House of Delegates

106th Annual Session
May 6-9, 1974
Biloxi, Mississippi

THE 71ST ANNUAL SESSION of the House of Delegates was eonvened during the 106th Annual Session of the Mississippi State Medical Association, in pursuance to lawful notice given, on May 6, 1974, in the Top of the Sheraton, The Sheraton-Biloxi, Biloxi, Mississippi, at 9:00 o'cloek in the morning by Dr. Arthur A. Derriek, Jr., of Durant, president. The invocation was spoken by the Rev. Roy Ott of Bethel Lutheran Chureh in Biloxi.

After extending greetings, Dr. Derriek presented the viee speaker, Dr. C. D. Taylor of Pass Christian, and the speaker, Dr. Walter H. Simmons of Jaekson, who assumed the ehair. Dr. W. Lamar Weems of Jaekson, ehairman of the Referenee Committee on Credentials, reported the presence of a quorum of 111 registered and seated delegates in aeeordanee with Seetion 3, Chapter V, By-Laws of the association.

ANNOUNCEMENT OF REFERENCE COMMITTEES

Reports of Officers and Board of Trustees
- C. G. Sutherland, Jaekson, Chairman
- Frank M. Wiygul, Jr., Jaekson
- Bedford F. Floyd, Gulfport
- William B. Hunt, Grenada
- Joseph E. Johnston, Mt. Olive

Medieal Praetiees
- Walter H. Rose, Indianola, Chairman
- George L. Arrington, Meridian
- Jack A. Stokes, Pontotoe
- James V. Ferguson, Greenwood
- R. J. Field, Jr., Centreville

Constitution and By-Laws
- Raymond S. Martin, Jackson, Chairman
- Tom H. Mitchell, Vieksburg
- Arthur E. Brown, Columbus

Rules and Order of Business
- W. Lamar Weems, Jackson, Chairman
- M. Beckett Howorth, Jr., Oxford
- Joe S. Covington, Meridian

Credentials
- James P. Spell, Jaekson, Chairman
- Rhea L. Wyatt, Holly Springs
- J. M. Griffith, Columbus

APPOINTMENT OF TELLERS AND SERGEANTS-AT-ARMS

The three viee presidents were designated as tellers. They are:
- Whitman B. Johnson, Clarksdale
- William M. Gillespie, Jr., Meridian
- David M. Owen, Hattiesburg

REPORT OF THE REFERENCE COMMITTEE RULES AND ORDER OF BUSINESS

To assist the speaker and viee speaker in the orderly eonduet of the proceedings of this House of Delegates, your Referenee Committee on Rules and Order of Business makes the following recommendations:

Conduct of Business: Under the By-Laws, the business of the House must be eonducted aeeording to *Sturgis Standard Code of Parliamentary Procedure,* and the speaker and viee speaker should preseribe the order of business as set out in the By-Laws. To insure proper reeording of the transaetions, all delegates reeognized should identify themselves. Exeept for distinguished visitors and those having offieial eapaeity in the association, unanimous consent should be obtained for extending the privilege of the floor to nonmembers of the House of Delegates. The report of the Referenee Committee on Credentials should constitute the formal and offieial roll call of the House.

Reference Committees. The purpose of reference eommittees is for affording all members of the association an opportunity to discuss their views on matters under consideration by the House of Delegates.

Reports. All reports and resolutions presented should be referred to the appropriate referenee committee by the chair immediately after their presentation, the only exception being those which are of

such a nature as to require no further consideration and are, therefore, ready for decision by vote of this House. Reports published in the *Handbook of the House of Delegates* are considered to have been formally presented and should be referred to appropriate reference committees by the chair. Debate should be reserved on all such presentations until such time as the reference committees conduct formal hearings and when they report to the House.

Resolutions. To avoid burdensome tasks upon the reference committees and to insure that all members have adequate opportunity to discuss their views, the House should permit no introduction of resolutions after the present meeting except for (1) matters of an emergency nature, the validity of such emergency to be determined by majority vote, (2) matters relating to a scientific section of scientific work, and (3) proposed amendments to the Constitution and/or By-Laws which would then lie on the table for one year.

The report of the reference committee was adopted.

ADOPTION OF TRANSACTIONS

On motion by Dr. Stanley A. Hill of Corinth, seconded by Dr. Lawrence W. Long of Jackson, the Transactions of the 70th Annual Session of the House of Delegates, 105th Annual Session of the association, April 30-May 3, 1973, published in Volume XIV, Number 8, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, August 1973, were adopted.

REMARKS OF THE SPEAKER

Dr. Walter H. Simmons: Two years ago in May 1972, I was elected vice speaker of this House of Delegates. At that time Dr. John B. Howell was elected speaker. As you know, he died April 3 of this year. He was a dedicated member of this body and I cannot recall having attended a meeting of this state association when he was not present. While he will be sorely missed by all of us, his absence will be of special importance to me as he was the one, of course, primarily to conduct this meeting. Shortly after his death, your president, Dr. Arthur Derrick, appointed me to the speaker's position the remainder of this term of office—through May 1975. And your president was especially kind to me to appoint as vice speaker, Dr. C. D. Taylor, an expert parliamentarian and a welcomed asset in this position.

We extend a warm welcome to you at this 106th Annual Session of the Mississippi State Medical Association. You who wear blue badges were elected to your position by your peers as an expression of confidence in your ability and diligence. Let each of us make a conscientious effort to contribute constructively to the work of this House. As has been said, "I pray that I may be not a part of the problem but a part of the solution."

Our democratic process requires full discussion on every matter before us and the opportunity to have your say is always before you. Our system of reference committees assures that each of you delegates—as well as any member of the association, has the opportunity to be fully heard on any question. Incidentally, any one not a member may also be heard by unanimous consent of the specific reference committee. We strongly urge—repeat—strongly urge—you to attend these reference committee hearings. Please do not take up the time of this entire body and incur the wrath of many of your peer delegates by discussing a matter which has been thoroughly thrashed out at a reference committee that you did not attend.

This meeting is conducted according to *Sturgis Standard Code of Parliamentary Procedure.* Your speakers will make every effort to rule impartially and with fair play. We will make mistakes but they will be honest mistakes. The remedy of challenge is always available to you. We will try and we ask you to try to follow the old army adage of "K.I.S.S.—Keep it simple, stupid."

I wish to quote from the Preamble of the Constitution of the Mississippi State Medical Association which appears inside the front cover of your program, "that more may live longer in the richness and comfort of health; that pain, suffering, and disease may be eradicated to the extent made possible by scientific medical knowledge; that the standards of the medical profession may be maintained on the highest plane of honor, we dedicate ourselves as physicians through this Association."

Gentlemen, let us go about our work to these noble ends.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the remarks of our speaker, Dr. Walter H. Simmons. We wish to associate ourselves with the speaker in noting how much we will all miss Dr. John B. Howell.

We commend our speaker and vice speaker for

the outstanding manner in which they have conducted the business of the House.

The report of the reference committee was adopted.

PRESENTATION OF DISTINGUISHED GUESTS

The speaker presented the following distinguished guests:

Mr. George Butler, President, Blue Cross and Blue Shield of Mississippi.

Mr. Sam. Cameron, Vice President, Mississippi Hospital Association.

Mr. Will Lowery, Assistant Director, Mississippi Medicaid Commission.

Mr. Tom Sawyer, Field Representative, American Medical Association.

Mr. Fred Andre, Field Representative, American Medical Association.

Mrs. Elizabeth Fulgham, Executive Assistant, Comprehensive Health Planning.

Ms. Lynne Bernabie, *South Mississippi Sun.*

Mr. Bobby Bishop, *Gulfport Daily Herald.*

Dr. James Robertson, Memphis, Tenn.

Mr. Jim Barnett and Mr. George Peters, University Medical Center student delegates.

ANNOUNCEMENT OF NOMINATING COMMITTEE

Following a recess for caucuses by association districts, the Nominating Committee was announced:

James V. Ferguson, Greenwood, District 1.

M. Beckett Howorth, Jr., Oxford, District 2.

Arthur E. Brown, Columbus, District 3.

Arthur A. Derrick, Jr., Durant, District 4.

C. G. Sutherland, Jackson, District 5.

Austin P. Boggan, Decatur, District 6.

W. Boyce White, Laurel, District 7.

Louis C. Lehmann, Natchez, District 8.

James T. Thompson, Moss Point, District 9.

Dr. Brown was elected chairman of the committee which conducted an open meeting on May 8, 1974, and posted the nominations for the information of all members in addition to submitting a written report of nominations to the House of Delegates.

ADDRESS OF PRESIDENT

The speaker declared the House of Delegates in open session, and the president, Dr. Arthur A. Derrick, Jr., delivered his address. The address has been published separately in Volume XV, Number 7, JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, July 1974.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee commends our president, Dr. Arthur A. Derrick, for his concise and excellent presentation. Dr. Derrick has been an outstanding president, and we are grateful to him in this regard.

In his address Dr. Derrick stated:

"I believe that we must develop a more informed and missionary zeal on behalf of our profession at the grass roots level. We must have better attendance at component society meetings. We must have more face to face communication between those in positions of responsibility in our state medical association and the membership. I am not talking about the staff here. I mean practicing physicians representing other practicing physicians on behalf of organized medicine.

"This will take time and effort. Time away from practice and effort to fully understand the many issues facing our profession today. Those called upon to serve should be fairly compensated. There should be no barriers to service. I recommend that this House of Delegates direct a committee of the House to study this matter and report back to the 1975 Annual Session."

Your reference committee appreciates the problem this recommendation addresses and is in complete accord with the recommendation.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

In his address to this House of Delegates our president, Dr. Arthur A. Derrick, recommended deletion of that part of Section 3, Article VI, MSMA Constitution, that requires nominees for office to have attended two-thirds of the past two and current annual sessions. Your reference committee has carefully considered this recommendation. It is our recommendation that this requirement be changed to provide that nominees for office attend one of the past two and/or current annual sessions. Since this would be an amendment to our MSMA Constitution, this recommendation must lie on the table for one year.

The report of the reference committee was adopted.

SPECIAL ADDRESS

Dr. Russell Roth of Erie, Pa., president of the

American Medical Association, addressed the House of Delegates as the principal speaker of the 106th Annual Session.

REPORT OF THE DELEGATES TO AMA

Your delegates to the American Medical Association, in conformity with custom and past practices, have limited their joint report to this House of Delegates to key policy actions at the annual and clinical conventions. Because of the comprehensive reporting in the *American Medical News* and *Journal AMA* of scientific and subsidiary activities, further reporting of these aspects of the AMA conventions would constitute needless duplication and repetition.

Dr. G. Swink Hicks of Natchez completed the second year of his two-year term Dec. 31, 1973, and he entered the first year of his next two-year term Jan. 1, 1974 (having been re-elected in May 1973). Dr. Joseph B. Rogers of Oxford completed the first year of his two year term on Dec. 31, 1973, and entered his second year Jan 1, 1974. Dr. Stanley A. Hill of Corinth completed the second year of his term as Alternate Delegate and began his first year of his second term Jan. 1, 1974 (having been re-elected in May 1973). Dr. Arthur E. Brown of Columbus entered his second year of his term as Alternate Delegate on Jan. 1, 1974.

This reporting covers the 122nd Annual Convention at New York City, June 24-28, 1973, and the 27th Clinical Convention at Anaheim, Calif., Dec. 1-5, 1973. Your delegation is indebted to our president and other officers and members who participated in these conventions and worked with us.

New York Annual Convention. The AMA House of Delegates confronted with the largest business agenda in the association's history acted on a wide range of issues during the 122nd Annual Convention (June 24-28, 1973) which affect physicians in their relationships with government, medical schools and hospitals, and with the public.

The issues ranged from PSRO's and wage-price controls to institutional licensure and the need for more primary care physicians. Meeting for a total of 18 hours and 51 minutes, the House acted on 84 reports and 179 resolutions for a total of 263 items of business.

As might be expected, PSRO was one of the major subjects before the AMA House. Two reports from the Board of Trustees outlining successful AMA efforts in providing physician input into the drawing up of PSRO regulations by the government, and in other areas, were filed by the House. In addition, two resolutions bearing on PSRO's were adopted. One resolution, initiated by California and amended, reads as follows:

> *Resolved,* That the Secretary of Health, Education and Welfare be informed that the only organizations which can give qualified peer review for physicians' services to the patient, physician, government and taxpayer are those composed of practicing physicians, whether these are state or local groups; and be it further
>
> *Resolved,* That since many of these practicing physician groups are functioning successfully, with multiple approaches, as peer review organizations, the regulations be so written to authorize these existing peer groups to continue their review as PSRO's or as functioning units of PSRO's, thus partially alleviating the unnecessary and costly implementation of new agencies as PSRO's.

The second resolution adopted was a substitute in response to a number of resolutions introduced, ranging from those calling for the AMA to go on record in opposition to PSRO's, to one urging the association to seek repeal of the law. The substitute resolution, which conforms to PSRO policy approved by the House at the 1972 convention, reads:

> *Resolved,* That although it is recognized that repeal or modification of PSRO legislation ultimately may be required to preserve high quality of patient care, the American Medical Association should oppose any facets of this current legislation which act to the deterioration of quality care, publicize such deleterious facets, and place highest priority on developing and pursuing appropriate amendments to preserve high quality of patient care.

Six resolutions were introduced protesting discrimination against physicians under the government's Economic Stabilization Program and the following substitute resolution was adopted by the House:

> *Resolved,* That the American Medical Association continue to work by all lawful and practicable means to assure non-discriminatory treatment for physicians under present and future Economic Stabilization Programs.

In other actions affecting the relationship of physicians with government (and third parties), the House:

—Encouraged continued efforts to develop a uniform claim form for insurance claims.

—Supported the on-going efforts to educate physicians, private insurance plans and government agencies as to the advantages of adopting the 3rd edition of Current Procedural Terminology to identify and report services provided by physicians.

—And directed the Council on Medical Service to study the problems presented by "prospective admission" of hospital patients under Medicare and Medicaid, and "retrospective denial" of benefits and report its findings and recommendations at the 1973 Clinical Meeting at Anaheim, California.

On the subject of institutional licensure, the House adopted a report of the Board which calls for the AMA to oppose the extension of institutional licensure in lieu of individual professional licensure to physicians and nurses. Testimony before the reference committee, including representatives of the nursing profession, was unanimously in support of opposition to institutional licensure.

Lengthy debate centered on a resolution from Illinois which protested unilateral changes in medical staff bylaws by hospital boards of trustees that usurp the prerogatives of hospital medical staffs. Similar situations were reported in Arizona and South Dakota. A motion from the floor to refer the resolutions was defeated. After considerable discussion, delegates approved the following substitute resolution:

Resolved, That the American Medical Association declares that any proposal or arrangement between a hospital board of trustees and its medical staff that conflicts with the AMA principles of medical ethics is improper; and be it further

Resolved, That unilateral changes in medical staff bylaws by hospital boards of trustees is also improper; and be it further

Resolved, That the AMA suggest that the following preamble be included in all medical staff bylaws:

The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the high quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgment and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff.

The House approved a report of the Board of Trustees concerning physician distribution by specialties which has important implications for the medical profession and for the public. The report outlines the increase in number of medical schools, the increase in approved residencies and internships, and the increased number of allied health and continuing medical education programs. The report, as amended by the House, contained two important recommendations. They are:

The AMA should adopt immediately, publicize widely and promote vigorously a goal to have at least 50 per cent of all medical graduates enter residency training in the primary care specialties in the coming years.

The need for numbers and type of physicians should be monitored continuously and reassessed periodically in regular reports to the House of Delegates.

On the subject of physicians' unions, the House adopted a resolution presented by the New York delegation which reaffirms the tradition of the medical profession of not withholding medical services (withholding services is a practice of most unions), or performing any act interfering with public welfare. The House also approved a Board of Trustee report which opposes unionism among self-employed physicians. The report also recognizes that physicians in employment situations need assistance and support, and encourages the Board of Trustees to maintain its interest and concern for these physicians. The report also affirms the no-withholding of services principle.

The House took several actions in regard to medical malpractice, including approval of a report from the Board of Trustees which outlines the proposed formation of a Medical Liability Commission to represent health care providers in dealing with medical malpractice problems. The proposed commission was outlined by a planning committee consisting of representatives of the AMA, AHA, American College of Surgeons, American College of Physicians and four specialty societies. An organizing meeting for the proposed commission will be held in Chicago in September.

After considerable discussion, the House voted

a change in the AMA Constitution and Bylaws to provide a seat on the Council on Medical Services and the Council on Medical Education for a representative from the intern-resident members of the AMA.

A great deal of discussion also took place pertaining to the separation of the business and scientific meetings of the AMA. No final decision was made and the meeting will continue as combined meetings through 1976 as contracts have been formalized to that date.

In other action the House instructed the Council on Constitution and Bylaws to prepare for the 1973 clinical session (Anaheim, California, December 1973) a measure that will allow the House to vote on whether Trustees shall serve a maximum of two, three year terms. The present maximum is three, three year terms.

The House adopted several recommendations on the subjects of membership certification and dues. They were:

Physicians shall become members of the AMA upon certification by state medical societies rather than by AMA receipt of dues.

The delinquency date for remittance of AMA dues is changed from June 1 to April 30 of each year, and the requirement that members who have been dropped for non-payment of dues must pay one year's past dues is eliminated.

The criteria for exemption from AMA dues shall be consistent with exemption from state medical society dues, except that members reaching their 70th birthday may apply directly to the AMA for Active Dues Exempt Membership status.

Elimination of the requirement that AMA membership be limited to those physicians in military service whose tour of duty is two years or more. Younger physicians serving two years or less in the military or the U. S. Public Health Service will be eligible for AMA membership, and county and state medical societies are encouraged to adopt this procedure.

In other actions, the House:

—Adopted a substitute resolution recommending that the AMA urge the enforcement of strict penalties for the use of firearms in the commission of a crime.

—Tabled a resolution urging AMA support for the open sale of condoms to minors.

—Referred to the Council on Mental Health a resolution urging AMA support of a model penal code decriminalizing sexual behavior between consenting adults, and AMA support to end legal and employment discrimination against homosexuals. The council was instructed to report back at the 1973 clinical meeting.

—Affirmed the traditional favorable attitude of the medical profession toward pregnancy and motherhood, and encouraged the development of counselling programs that will offer constructive help to prospective mothers in coping with the stresses of pregnancy.

—Reaffirmed the AMA abortion policy which states "Abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in accredited hospitals acting only after consultation with two other physicians, and in conformance with standards of good medical practice and the Medical Practice Act of his state. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of good medical judgment or personally held moral principles."

Officers elected were Russell B. Roth, Pennsylvania, installed as President; Malcolm C. Todd, California, President-elect; E. Bryce Robinson, Jr., Alabama, Vice President; Tom E. Nesbitt, Tennessee, Speaker of the House; William Y. Rial, Pennsylvania, Vice Speaker of the House; John H. Budd, Ohio, Richard E. Palmer, Virginia, James H. Sammons, Texas, and Kenneth C. Sawyer, Colorado, AMA Board of Trustees; George H. Mills, Hawaii, Judicial Council; John H. Burkhart, Tennessee, Council on Constitution and Bylaws; J. Jerome Wildgen, Montana, Russell S. Fisher, Maryland, Louis Burgher, Minnesota (resident-intern member), Council on Medical Education; Hector W. Benoit, Jr., Missouri, Drew M. Peterson, Utah, Daniel Ostergaard, Minnesota (resident-intern member), Council on Medical Service.

(This report was prepared by G. Swink Hicks, M.D., of Natchez, Delegate to AMA.)

Anaheim Clinical Convention. The AMA House of Delegates elaborated on its policy position on Professional Standard Review Organizations (PSRO) during the 27th Clinical Convention of the AMA in Anaheim, Dec. 1-5. The House also addressed itself to problems arising from federal wage and price controls over health care providers as well as numerous other issues of concern to physicians and the public.

Meeting for a total of 14 hours and 36 minutes, the House acted on 67 reports and 81 resolutions for a total of 148 items of business, the biggest agenda for a Clinical Session in recent years.

Other issues considered ranged from malpractice problems to proposed improvements in health care delivery for migrant workers, and the method of election—and terms of service—of members of the Board of Trustees.

A total of 10 resolutions concerning the PSRO Law were introduced during the clinical session, more than for any other item of business. Reference Committee A, which began its hearings of PSRO shortly before noon Monday, Dec. 3, heard more than four hours of testimony from physicians expressing various shades of opinion, and did not complete its preliminary report until the early morning hours of Tuesday.

After more than two hours of additional discussion on PSRO's on Wednesday, the House of Delegates adopted Report EE of the Board of Trustees, as amended, in lieu of the various resolutions which had been submitted. The report summarized PSRO developments to date and outlined previous AMA policy in confronting the PSRO issue. The House adopted the following amendment to Report EE of the Board of Trustees:

"The AMA affirms the following principles:

"1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

"2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

"3. That the association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

"4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality, and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public. The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our longstanding policy and opposition to this legislation prior to passage."

In adopting the above amendment, the House made special note that the last paragraph of Report EE remains the same. The last paragraph reads:

"The considered opinion of the Board of Trustees and the Council on Medical Service is to recommend to the House of Delegates that the AMA continue to exert its leadership and support constructive amendments to the PSRO law, coupled with continuation of the effort to develop appropriate rules and regulations."

Four resolutions and two reports were introduced dealing with discriminatory Phase IV Wage-Price Controls on health care providers and institutions. The House approved a Board of Trustees report announcing AMA support for the American Hospital Association in its battle against proposed controls over acute care hospitals. Delegates also adopted a substitute resolution which directed the AMA to continue "as a matter of high priority" to seek relief for physicians from wage-price controls "using all available administrative resources," and that "the Board of Trustees be authorized to institute appropriate legal action when so advised by legal counsel."

In opening-day remarks which drew a standing ovation from the House, Dr. Russell B. Roth, president of the AMA, discussed some of the complex issues surrounding peer review and Professional Standards Review Organizations.

The only way to effectively assure high quality care is through professional peer review, Dr. Roth said, because "ultimately, excellence of medical care is determined by the competence, the motivation, and the integrity of the physician who provides it."

The problem with most lay-initiated peer review proposals is that they are based on the mistaken premise that good health care can be provided through improved delivery systems or institutionalization, according to Dr. Roth.

"Since the delivery of most medical care takes place outside the hospital, and because the quality of care is not something that can be measured in dollars of cost or hours of time, peer review standards such as those proposed under PSRO will be difficult to establish," he said.

"Regardless of how one may derive standards and norms, the matter of judging conformity and of evaluating exceptions and divergencies is a peer professional problem.

"We should reflect that a medical school is regarded as good because it is adjudged to be so by physician graduates, physician faculty members, and physician contemporaries."

Dr. Roth added that more attention will be paid to evidence that physicians are keeping abreast of medical progress and are maintaining their medical competence, but he said that "This too will undoubtedly be accomplished by peer evaluation."

Dr. Roth did not take sides on the PSRO question, but spoke for "the good and useful things that we may do to identify high quality of care, and of the immense difficulties in doing this well."

But Dr. Roth concluded that "If solutions were to come easily it would not be a challenge—and challenge it is. In the meantime the nation will be well advised to put its confidence in the competence, the integrity, and the motivation of the medical profession."

Because of the wide-ranging nature of the actions taken by the House of Delegates, and for the sake of clarity, this summary report will be divided into four subject areas with appropriate subheadings: Physicians and Hospitals and Medical Schools; Physicians and the Public; Association and Internal Matters of the House; and Miscellaneous.

Physicians and Hospitals and Medical Schools

Preadmission Certification—The House considered two resolutions dealing with proposed government regulations that would impose a hospital preadmission certification program for patients under Medicare. A resolution adopted by the House directed the AMA to take all steps necessary to prevent enactment of regulations mandating hospital preadmission certification and to determine whether such regulations would be in violation of Medicare law.

Another resolution which would have the AMA request the Secretary of HEW not to allow the publishing of preadmission certifications in the *Federal Register,* and also would have the AMA seek Congressional support for this position, was referred to the Board of Trustees and the Council on Legislation. (Note: Subsequent to the meeting, the Secretary officially published proposed preadmission certification requirements in the *Federal Register* and the AMA officially stated its intent to seek legal redress if the proposed regulations were made final.)

Funding Medical Education—A report from the Board of Trustees, which outlines continuing AMA efforts to secure balanced funding for medical education and research, was adopted by the Delegates. The report describes several studies of the cost of medical education and its relation to the cost of medical care that are presently underway, and points out that the Council on Medical Education is closely monitoring the results of such studies with a view toward future actions.

Quality Assurance Program—After considerable discussion, the House adopted a resolution that offers the American Hospital Association the cooperation of the AMA in deliberations on the AHA's Quality Assurance Program. The AMA will seek the elimination of features it considers undesirable. A final resolve puts the AMA on record as disapproving the QAP in its present form.

Intern and Resident Matching Program—The House adopted a report of the Board of Trustees which recommends that the present National Intern and Resident Matching Program remain in effect. Two resolutions introduced at the 1973 Annual Session had proposed that the National Matching Program abandon its "all or nothing" policy. Testimony before the reference committee which considered the matter indicated students endorsed the Board report. The committee added that further study of the matching program is being conducted by the Liaison Committee on Graduate Medical Education and the Coordinating Council on Medical Education.

Physicians and the Public

Health of Migrant Workers—Development of a possible nationwide health insurance program for migrant workers is one of several proposals contained in a Council on Medical Service report approved by the House.

The report states that such an insurance program is possible and adds that there is a need for migrant health advocates who would be paid for their services rather than be volunteers.

Under action taken by the House, the Council on

Medical Service is instructed to develop a version of such an insurance program.

Confidentiality of Records—The House adopted a report of the Council on Medical Service that describes efforts to find practical solutions to problems related to maintaining the confidentiality of patient records. The House further instructed the council to prepare model legislation to preserve confidentiality as a guide to possible state legislation. Also adopted was a resolution that puts the AMA on record in opposition to violation of the confidentiality of patient records by government agencies under all circumstances.

Alcoholism—Under a resolution adopted by the House, the medical treatment and admission of alcoholics would be improved. The resolution recommends to the American Hospital Association that it urge member-hospitals to liberalize admission policies for alcoholics where necessary, urges physicians to abstain from using the names of other pathological conditions in lieu of alcoholism, urges the Joint Commission on Accreditation of Hospitals to implement the intent of the resolution as one of its requirements for approval, and urges insurance companies and prepayment plans to remove unrealistic coverage limitations for treatment of alcoholics.

Health Care of the American Indian—The House adopted and referred to the Board of Trustees for further action a report by the Council on Medical Service and its Committee on Health Care of the Poor regarding proposed improvements in the Indian Health Service. The report summarized the total picture of Indian health, and contained recommendations on how to improve the Indian Health Service programs of the federal government.

National Blood Program—The concept of the proposed AMA plan to implement the government's National Blood Policy by organizing blood banks and transfusion facilities within a national system that retains regional and local responsibilities and authority was endorsed by the House.

Definition of Death—Because of complex legal ramifications, the House adopted a policy position that at present the statutory definition of death is not desirable or necessary, that state medical associations urge their legislators to postpone enactment of definition of death statutes. The House also affirmed the following statement: "Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria.

The Dying Patient—The House adopted the following statement to serve as a guideline for physicians confronted with ethical problems related to euthanasia (mercy killing) and death with dignity:

> "The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
>
> "The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family."

Association and Internal Matters of the House

Terms of Service of Trustees—Proposed amendments to the by-laws that would have limited members of the Board of Trustees to a maximum of two full terms of three years each were not adopted by the House. The action retains the present provision allowing trustees to serve three full terms of three years each.

Method of Electing Trustees—In a related action, the Delegates approved two other resolutions that will allow candidates for the American Medical Association Board of Trustees to run at large rather than for designated "slot" positions as is presently done. One of the resolutions adopted outlines the methods to be followed in at-large election of trustees, while the other deals with any necessary changes in the by-laws.

Specialty Representation in House—The House took several actions related to direct representation of national medical specialty societies in the House of Delegates. The House adopted a report of the Council on Constitution and Bylaws calling for a thorough study of the proposal including an open hearing at the 1974 Annual Meeting. Two resolutions, both calling for the rejection of direct representation by the specialty societies, were referred to the Council on Constitution for consideration in its study.

Professional Liability—A report of the Board of Trustees, which summarizes the development of the new Medical Liability Commission formed by the AMA, AHA, and several national medical specialty organizations, was endorsed by the House. Delegates further directed that the Board of Trustees "grant

the highest priority for financial and organizational support" for the commission.

The Board of Trustees will request that the commission give some priority to basic research in the field of medical liability and will urge the present Secretary of HEW to consult and cooperate with the commission.

The action also puts the House on record as urging all delegates, state and local medical associations, and other medical organizations to support the new commission, and to submit to it any appropriate comments, suggestions, or ideas for easing malpractice problems.

Renal Dialysis—Acting on a report from the Council on Medical Service and on several resolutions, the House adopted a strong policy position on renal dialysis and transplant procedures under Medicare. The report and resolutions objected to the "interim regulations" issued by the federal government in respect to renal dialysis and transplant under Medicare, since the regulations establish what is tantamount to a maximum fee schedule on a national basis for professional services, and in effect dictate on a national scale the method by which certain kinds of medical care are rendered.

Under actions taken by the House, the AMA will strongly protest—and seek to rescind—the interim regulations; request that the federal government return to existing systems of determining medical necessity for treatment and setting fees; and—with consultation from concerned medical specialty societies—work with the government in redrawing the interim regulations.

In miscellaneous actions, the House:

—Referred to the Council on Medical Service a resolution urging the AMA to oppose wide differences in fees for medical services performed by equally qualified physicians who practice in different geographic areas of a state. . . .

—Adopted a report recommending that summaries of court decisions on informed consent be made available to physicians on request rather than the compilation of model guidelines since court interpretations of informed consent vary from one jurisdiction to another. . . .

—Adopted a substitute resolution calling for the Board of Trustees, the Interns and Residents Business Section, the Council on Medical Service, and the Council on Medical Education, to develop principles and guidelines for agreements between House staff and their institutions, and to explore the development of a model contract for use by institutions with graduate medical education programs. . . .

—Approved a proposal that the 1977 Annual Meeting be held in San Francisco and the 1977 Clinical Session in Chicago. . . .

—Adopted a report of the Council on Medical Service outlining progress made in persuading the Aetna Life and Casualty Company to limit the use of its surgical predetermination form. . . .

—Endorsed Board of Trustees action in supporting the enactment of legislation for medical devices. . . .

—Referred to the officers of the Interns and Residents Business Section and the Board of Trustees a resolution seeking AMA support for an exemption from federal taxes of the first $3,600 of annual income paid post-doctoral trainees by institutions accredited by the AMA Council on Medical Education. . . .

—Filed a report stressing the record growth of the American Medical Association Education and Research Foundation. . . .

—Adopted a substitute resolution encouraging the observance of due process in disputes involving interns and residents and the institutions in which they work.

Expression of Delegates. Your AMA Delegates express their appreciation to our own House of Delegates, to the Board of Trustees with whom we sit at all meetings, and to the general officers for support, assistance, and continuing communication so that we may be properly prepared to represent your wishes and policy positions.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the reports of our delegates to the American Medical Association, Drs. G. Swink Hicks and Joseph B. Rogers. We commend our delegates for the outstanding job they do in representing Mississippi medicine in the AMA House of Delegates.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Organization and Duties. The Council on Scientific Assembly is a constitutional body of the House of Delegates, charged with the responsibility of

planning the annual session of the association to include all scientific activities, programming, and the scheduling of annual session events. The council membership consists of the chairmen and secretaries of the seven scientific sections and the secretary-treasurer of the association, a total of 15 members.

106th Annual Session. Planning and organization of the 106th Annual Session was initiated in the summer of 1973. The format suggested in the By-Laws and approved by the House of Delegates has been continued with general sessions centered around broad areas of specialty interests. To the maximum possible extent, conflicts in schedules and programming have been eliminated, although as a practical matter, such total elimination is not possible. In some instances, the council has requested and placed essayists from various specialty societies not represented in the Scientific Assembly before section audiences.

We are gratified that at the present annual session, 15 specialty societies have related or concurrent meetings with us. Four medical alumni groups have fraternal and social occasions, and various non-scientific but medically related bodies will meet during May 6-9. We continue to believe that providing for and encouraging these related meetings increases the attractiveness of the annual session to the membership and benefits attendance. We are glad to continue support of the Woman's Auxiliary and its concurrent annual session with us.

Medical television on the agenda for the 106th Annual Session will feature films sponsored by the the Davis and Geek Suture Company and coordinated with presentations before the seven scientific sections. Also to be shown are a State Board of Health film on alcoholism and a Wayne State University film on respiratory distress syndrome.

Technical Exhibit. Your council notes that ethical pharmaceutical firms, suppliers, and others eligible for purchase of space in our Technical Exhibit are declining our invitation to participate in growing numbers. This is not confined to Mississippi, because other state medical associations, major state specialty societies, and national organizations are having the same experience.

Federal drug legislation, changing concepts in marketing, and tighter budgets for advertising have taken a toll of technical exhibit revenues. We have circularized more potential exhibitors than ever before and are placing emphasis on attracting exhibits from investment and other interested firms. We continue to do all things possible to increase this participation.

Presentations in the scientific exhibit number over 20 this year. We urge every member and guest to view these educational exhibits and the technical exhibits.

New Features. Your council, in an effort to increase attendance and participation, has instituted several new features this year. On Tuesday morning an association-wide fellowship breakfast will be held. A poolside hamburger party for teenagers is planned and babysitting facilities and kiddie movies will be available. A special floor show is planned for Tuesday night on the Top of the Sheraton. An extensive promotional campaign is being conducted through the JOURNAL MSMA and the Blue Sheet.

Headquarters Hotel. The annual session will be held at the Sheraton-Biloxi for the fourth year. The council chairman and the MSMA executive staff have conducted extensive consultations with the Sheraton staff in the hope of improving service in the hotel.

Expression of the Council. Your Council on Scientific Assembly is grateful for the support, cooperation, and assistance we have received in planning the 106th Annual Session of the association.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the report of our Council on Scientific Assembly. We commend the council for the outstanding work it has done in organizing and planning this annual session. This has truly been one of the finest annual sessions ever held by the association.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

Organization and Duties—The Council on Medical Service is a constitutional body of the House of Delegates, consisting of nine members, one from each association district, elected for terms of three years each. There are three ex officio members who are our president, president-elect, and secretary-treasurer. The council is charged with the responsibility of ascertaining and studying all aspects of medical care in Mississippi. Under the council's jurisdiction are assigned activities of the association in medical service, emergency service programs, medical care for the indigent, and the work of allied medical agencies and organizations.

The council is assisted by five committees, four constitutional and one ad hoc. These embrace a wide range of subject areas, including maternal and child care, blood and blood banking, mental health, nursing, and college health.

Committee on Nursing—The Committee on Nursing serves as the association's liaison committee with a similar committee of the Mississippi Nurses Association. Based on recommendations of the committee contained in "Supplemental Report A of the Council on Medical Service" to the House of Delegates at the 1973 annual session, the committee has worked with the MNA in formulating and coordinating legislation to provide for an expanded role for the RN based on local needs and desires and as approved by the Mississippi State Board of Health and Mississippi Board of Nursing. HB 436, 1974 Regular Session of the Mississippi Legislature, provides statutory authority to implement this expanded role concept. In anticipation of final favorable action on the bill the committee has offered its services to the Mississippi State Board of Health in a consulting capacity to assist in setting standards for the expanded role of the nurse and this offer has been accepted.

The committee is also concerned with patient care provided in nursing homes and in this regard the committee has met with professional staff of the Mississippi Medicaid Program's Nursing Home Services staff. The February, 1974 JOURNAL MSMA article entitled "Problems, Needs, and Preparation of Nurses in Nursing Homes in Mississippi" represents an agenda for future action to improve patient care provided in nursing homes in Mississippi.

Committee on Maternal and Child Care—The Committee on Maternal and Child Care continues its study of maternal deaths in Mississippi. A report on "Maternal Mortality in Mississippi: 1970-1971" appeared in the March 1974 JOURNAL MSMA. Based on numerous questions and concern over the status of abortion in Mississippi in view of both the U. S. and Mississippi Supreme Courts' decisions on this subject, the committee prepared a "Statement on Abortion" for adoption by the association as a "discussion" of the legal and medical aspects of abortion. This was published in the January, 1974 JOURNAL MSMA. The committee is presently revising its "Maternal Health Desk Cards" for distribution within the next few months.

Committees on Mental Health, Blood, and College Health (ad hoc)—These committees of the council have continued activities in their respective areas of assigned interest. Although not directly involved in efforts to reorganize the state's mental health programs, individual members of the Committee on Mental Health, the association's Council on Legislation, and the Mississippi Psychiatric Association have been actively involved in formulating legislation before the 1974 Mississippi Legislature dealing with this subject matter. The Committee on College Health has held meetings over the past several months devoted to drafting a survey form for studying health services offered in Mississippi colleges and universities and the chairman of the committee represented the association at the 1973 AMA-American College Health Association Annual Meeting.

Other Council Activities—The council has considered other subject matter following within its sphere of assigned interest and wishes to bring the following information and recommendations to the attention of the House of Delegates for such action as deemed appropriate.

Public Law 93-222: Health Maintenance Organization Act of 1973. The Congress passed and the President signed on Dec. 29, 1973, Public Law 93-222. This law creates a new title in the Public Health Service Act which authorized assistance for the *development* and *operation* of what are to be known as Health Maintenance Organizations (HMOs).

As defined by law, an HMO must be a legal entity which is composed of those health professionals necessary to provide the services required of an HMO (noted below) the majority of such health professionals being licensed physicians or osteopaths. The members of the legal entity must as their principal professional activity and as a group responsibility engage in the coordinated practice of their professions for an HMO and must pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other plan.

The HMO's services must be prepaid by its subscribers. A set monthly premium is charged and such premiums must be "community rated," i.e., payments are determined on a per-person or per-family basis and may vary with the number of persons in a family but will be equivalent for all individuals and for all families of similar composition. Each HMO must schedule a 30 day "open enrollment" period each year and no prospective subscriber may be turned down as a "poor risk" unless the HMO's

subscriber rolls already include too many "poor risks."

The HMO must provide the following "basic" services to all subscribers on a 24 hour basis: (a) physician services; (b) emergency services; (c) short term (not to exceed 20 visits) outpatient evaluative and crisis intervention mental health services; (d) medical treatment and referral services for the abuse of or addiction to alcohol and drugs; (e) diagnostic lab and x-ray services; (f) home health services; (g) preventive health services (including family planning, infertility services, preventive dental care for children, and children's eye examinations).

Federal HMO funding is provided as follows: (1) grants of up to $50,000 to public and non-profit groups to support HMO feasibility studies; (2) grants of up to $125,000 to a qualified (HMO) group for planning and development or for expansion of existing HMO-type health plans; (3) HMO operational loans of up to $2.5 million to offset losses incurred during the first 36 months of operation.

Other important HMO provisions are: (1) no state may establish or enforce laws preventing or restricting the development of HMOs; (2) HMOs must give their subscribers one-third representation on all policy-making bodies and must provide health education services to subscribers and set up procedures to resolve grievances between subscribers and the HMO; (3) every employer covered by the minimum wage laws must offer his employees an HMO option, if one is available, in lieu of their present health insurance coverage—any increased premium costs, however, must be borne by the employee; (4) HMOs are encouraged to serve rural and "medically underserved" areas.

Recommendation. As noted above, a state cannot enforce laws which restrict and/or prevent the operation of HMOs as provided for by Public Law 93-222. The legal status of an HMO in Mississippi is hazy. A bill was introduced during the 1974 session of the Mississippi Legislature which would have established some basic standards for HMOs to be administered by the State Insurance Commissioner. The bill died in committee and it now appears that the only state laws relating in any way to an HMO are those under which Mississippi Blue Cross and Blue Shield, Inc. is organized. The Council on Medical Service recommends that the association furnish appropriate leadership and guidance in defining the legal status of HMOs in Mississippi.

Exploring Medicine and the Allied Health Careers Programs—The Boy Scouts of America is seeking the support and guidance of the Mississippi State Medical Association and its constituent societies in organizing Medical Explorer Programs in Mississippi. The BSA Medical Exploring Program is similar in format to other BSA Exploring Programs in medicine, banking, law enforcement, etc. It is open to young men and women 15 to 21 years of age and at present some 46,000 young people belong to 1,700 medical explorer posts. In 1972 the American Medical Association provided a three-year grant to the BSA to help expand the Medical Explorer Program.

The two main ingredients necessary to form a medical explorer post are young adults interested in health careers and sponsoring organizations. It is in regard to the latter that the medical society can play an important role. Sponsorship of Exploring involves the development of a program, providing meeting facilities, selection and approval of leadership, and making necessary resources available. The local BSA Exploring Division in Mississippi will assist with program development, training of personnel, volunteer and professional staff support, central registration and office services, and local and national events and activities in support of the post. The program is provided without cost to the sponsor although many organizations budget modest amounts to assist the Explorers with their activities.

Recommendation. The Council on Medical Service recommends the association's formal support and guidance in organizing the BSA Medical Exploring Program in local medical societies throughout the state.

The Physician's Assistant—At the 105th Annual Session, the House of Delegates considered the new and expanding health profession called the "physician's assistant" and went on record as "opposing the licensing of physician assistants . . ." and stating "that such health professionals should work under the direct supervision of physicians." During the 1974 Regular Session of the Mississippi Legislature, confusing and potentially unfortunate efforts were made to recognize and regulate the physician assistants. Such efforts were prompted, among other reasons, by the fact that there are physicians in Mississippi employing PAs.

Recommendation. The council recommends that the House of Delegates reaffirm its position on physician assistants (i.e., PAs not be licensed and work

under the direct supervision of a physician) and further urge legislation in this regard to empower the physician members of the Mississippi State Board of Health to approve and certify a physician's employment of a physician's assistant and to approve and certify proposed functions of the physician's assistant as described by his physician employer. The use of the term "physician's assistant" in this context refers solely to the new occupations being developed to assist the physician in delivery of personal care services.

Amendments to the Medicare-Medicaid Programs —The council has considered the extensive amendments to the Medicare and Medicaid Programs enacted by the Congress in Public Law 92-603. These amendments were the basis of an article entitled "Report of the Council on Medical Service: Medicare-Medicaid Amendments" published in the December 1973 JOURNAL MSMA.

Recommendation. The council urges each member's attention to the article "Report of the Council on Medical Service: Medicare-Medicaid Amendments." Further, the council has considered the nomenclature of physician services used by Medicare, Medicaid and other third party payors and the relationship of physicians' usual, customary, and reasonable fees in Mississippi to payments for physicians' services by Medicare, Medicaid, and other third party payors. The heretofore "secret" Medicare prevailing fee guidelines were made available by a court order. The council is aware of and commends the work of the Mississippi Foundation for Medical Care in this subject area based on actions of the House of Delegates. The council recommends that the American Medical Association be called upon to furnish leadership in compiling, analyzing, and publishing Medicare "prevailing fee guidelines" used throughout the United States.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

The report of the Council on Medical Service as set forth on pages 18-21 of your House of Delegates Handbook includes four separate and distinct recommendations. The first of these recommendations asks the association to furnish appropriate leadership and guidance in defining the legal status of HMO's in Mississippi. The second recommendation calls for the association's formal support and guidance in organizing the Boy Scouts of America Medical Exploring Program in local medical societies throughout the state. The third recommendation asked for a reaffirmation of the association's position on physician assistants and further urges legislation to empower the physician members of the Mississippi State Board of Health to approve and certify a physician's employment of a physician assistant and to approve and certify proposed functions of the physician assistant as described by his physician employer. Your committee took special note of the fact that the use of the term "physician assistant" in this context refers solely to the new occupations being developed to assist a physician in delivery of personal care services. The fourth recommendation urges each member's review of the article "Report of the Council on Medical Service: Medicare-Medicaid Amendments" and further recommends that the American Medical Association be called on to furnish leadership in compiling, analyzing, and publishing Medicare prevailing fee guidelines used throughout the United States.

Your reference committee feels that the council's report is timely, comprehensive, and indicative of the issues which our profession must be concerned with. Your reference committee therefore concurs with and recommends the adoption of each of the council's recommendations.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT A OF THE COUNCIL ON MEDICAL SERVICE

Background. Hospital/medical staff relationships continue to be a growing area of professional concern. In recent years such subjects as physician representation on hospital governing boards, charges by hospitals for house staff services, medical staff responsibility for peer review, and others dealing with hospital/medical staff relationships have been matters of concern to members of the Association both individually and collectively before this House of Delegates. The Council on Medical Service wishes to bring the following recent actions on these several subjects to the attention of the House of Delegates and general membership of the association.

1. *Physician Representation on Hospital Governing Boards.* In 1967, the association's House of Delegates adopted a report from the council which stressed the need for close liaison between medical staffs and governing boards of hospitals and recommended that each hospital in the state have at least two voting doctors of medicine on its governing board. At its recent convention in February 1974,

the American Hospital Association adopted the following statement:

"Where legally permissible, physicians actively practicing in the community, who are members of the medical staff, shall be eligible for, and it is recommended that they be accorded membership on health care institution governing boards. They should be selected for their ability to assist the institution in achieving its goals. Their charge should be no different than for any other board member. Every board member, including physician board members, should recognize that his or her leadership must be directed toward assisting the institution in providing the needed health care services to the community served by that institution."

2. Hospital Governing Board/Medical Staff Relationships. Concern over actions by hospital boards of trustees that usurp the prerogatives of hospital staffs has led the AMA House of Delegates to declare that any proposal or arrangement between a hospital board of trustees and its medical staff that conflicts with the AMA principles of medical ethics is improper. Further, unilateral changes in medical staff bylaws by hospital boards of trustees are also improper. The following preamble has been advocated for inclusion in all medical staff bylaws:

"The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the highest quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgment and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff."

3. *Medical Staff Control Over Use of New and Expanding Health Professions.* New health professions are being created and older professions are expanding their scope. Their activities frequently are those that were formerly carried out only by physicians.

To assure proper medical control over the activities of such new or expanding allied professionals, the AMA House of Delegates has adopted a statement on the "Status and Utilization of New or Expanding Health Professionals in Hospitals." The statement covers regulation of such categories as the new physician-support occupations generically termed "physician assistants" and those allied health professionals and nurses functioning in an expanded role. It is not intended to cover regulation of nurses and allied health professionals performing in their regular and customary roles nor nurse practitioners functioning within the legal definition of nursing.

The new statement, adopted in June 1973, reads as follows:

"1. The services of certain new health professionals as well as those professionals assuming an expanding medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three following criteria:

a. As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care.

b. They participate in the management of patients under the direct supervision or direction of a member of the medical staff, who is responsible for the patient's care.

c. They make entries on patients' records, including progress note forms, only to the extent established by the medical staff.

"2. The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws:

a. Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as for medical staff membership and privileges.

b. The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant.

c. In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions."

Recommendation. Your Council on Medical Service recommends that items 1, 2, and 3 above be brought to the attention of each hospital chief-of-staff in Mississippi.

4. *Report on Physician/Hospital Relations.* In 1964 the AMA's Council on Medical Service presented an extensive report on physician/hospital relations which proved to be a valuable reference for medical staffs, medical societies, and individual physicians in dealing with physician/hospital relations. In 1970 the council began a program to review and update its 1974 report and this work has now been completed and is ready for study and comment on by state medical associations prior to presentation to the AMA House of Delegates at its June, 1974 annual meeting. A summary of these recommendations follows:

a. It is recommended that county medical societies be urged to consult with and work in mutual cooperation with medical staffs of hospitals in their areas to develop uniform local standards for granting privileges in general and special hospitals in the communities served.

b. It is recommended that the AMA undertake a study of practicing physicians not having hospital appointments and the factors responsible for their lack of affiliation with hospitals.

c. It is recommended that the AMA develop educational materials including audiovisual presentations for use in hospital-based training programs for medical staff officers. State and county medical societies should be urged to endorse and promote such training programs.

d. It is recommended that the AMA in its continuing efforts to increase and expand socioeconomic training for medical students, interns, and residents, urge that such courses contain practical and realistic information on physician/hospital relations and particularly on physicians' responsibilities to contribute to management decisions.

e. It is recommended that the American Medical Association urge that the professional prerogatives of physicians be protected when medical staff bylaws are developed and the organized medical staff accept the responsibility for continuing effective, vigilant efforts to ensure that the bylaws as duly adopted by the medical staff and approved by the governing body are adhered to by all medical staff members including those who are full or part-time salaried employees of the hospital or who have other contractual financial arrangements with the hospital. In maintaining high quality medical care standards in the hospital, it is essential that the organized medical staff assume full responsibility for these vigilant efforts. The hospital governing body and the administration should recognize that medical administrative matters are within the purview of the organized medical staff and should not interfere in matters requiring the exercise of professional judgment unless the organized medical staff fails to fulfill its responsibilities and obligations.

f. It is recommended that in contracts between individual physicians and hospitals for the provision of professional medical services, it be recognized as an acceptable practice for the physician to agree to accept the guarantee of a stipulated income from the hospital. In any instance, fees shall be collected for the physician's professional medical services and may be billed by the physician or by the hospital acting as his agent. Where the hospital acts as the physician's agent, its billing shall clearly delineate the fee for the physician's professional services. If fees collected for the physician's professional medical services exceed the guaranteed stipulated income, the excess amount shall be payable to the physician and shall be under his direct control to do with as he sees fit. Any deficits in the total fees received, whether billed by the hospital or by the physician, should be borne by the hospital.

g. It is recommended that the AMA undertake a pilot study of several "physicians-on-call" groups to determine their effectiveness and make recommendations regarding their roles in the health care delivery system, particularly in the hospital setting.

h. It is recommended that the House of Delegates urge the Council on Medical Education to recognize that a program director is as acceptable as a chief of service in considering all "essentials" or "requirements" for graduate training programs.

i. It is recommended that medical staffs in hos-

pitals with graduate medical education programs be urged to develop materials for distribution to patients describing the hospital's educational functions and the respective roles of physicians cooperating in patient care. These materials should be developed with cooperation of both salaried and nonsalaried physicians and approved by a majority of the entire medical staff.

j. It is recommended that the operation of an effective teaching program be recognized as a team effort involving the attending physician, the teaching attending physician, the house officer, and the program director, and having the dual goals of improving patient care and providing graduate and continuing education. The relationships of the physicians must include consultative procedures both in the care of the patient and in the educational processes. If there is a referring physician, he should also be considered a member of the team and he too can be expected to benefit from the educational process in patient rounds.

k. It is recommended that each hospital medical staff assume responsibility to ensure that in all teaching situations the rights of the patient and the responsibilities of the attending physician not be abrogated.

l. It is recommended that hospitals be urged to make available routinely to the medical staff copies of lists of rates and charges for rooms and for common tests and procedures.

m. It is recommended that hospital governing boards, administrators, and medical staffs consult on a regular basis about rates and charges and mutually cooperate in efforts to find ways to lower costs in any feasible way.

n. It is recommended that physicians be urged to continue their efforts to order only measures necessary for the diagnosis and treatment of their patients. Their consideration should of course be based upon selection of optimum care procedures, but when alternative measures of equal effectiveness are available at different costs, their selection should include consideration of costs.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

This report recommends that pages one, two, and three of Supplemental Report A of the Council on Medical Service dealing with Hospital Administration/Governing Board/Medical Staff relationships be brought to the attention of each hospital chief of staff in Mississippi. Your reference committee believes that this report is a vitally important statement on the entire scope of physician/hospital relations and recommends that it be adopted and distributed pursuant to the council's recommendations.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

Based upon prior actions of the House of Delegates, the Council on Medical Education submitted a "Plan of the Mississippi State Medical Association for a Program of Survey and Accreditation of Institutions and Organizations with Continuing Medical Education of Local Scope and Focus" to the AMA Council on Medical Education for approval. On Dec. 13, 1973, the MSMA headquarters office was notified of one year provisional approval of the "PLAN" for Continuing Medical Education in Mississippi.

Your Council on Medical Education, during the past year, has been coordinating its efforts with its *Ad Hoc* Committee on Continuing Medical Education and the EMCRO. The first problem, recognized by the council in attempting to accredit continuing medical education programs, was a lack of such organized programs on a local hospital basis. Through the EMCRO, however, two pilot projects were funded; one at the Mercy Regional Medical Center in Vicksburg, and one at the Greenwood-Grenada-Winona trade area. These two projects are developing their own local, community hospital-based CME programs. Following the guidelines recommended by AMA and MSMA, these two projects are developing their own "Objectives" and "Plan" in preparation for the accreditation survey.

The initial survey is to be conducted at the Mercy Regional Medical Center in Vicksburg and is tentatively set for May of this year. As a result of this survey, any physician participating in a Continuing Medical Education program at Mercy Hospital in Vicksburg will be able to earn credit hours toward the AMA's Physician Recognition Award or the hours required by the AAFP. This same process will take place with the Greenwood-Grenada-Winona trade area. These three hospitals will have their individual programs, as well as those for the considered region.

As experience is gained by your council and its *Ad Hoc* Committee matures, additional surveys for Continuing Medical Education program accreditation will be scheduled. With this in mind, a manual, to be used by hospitals interested in developing a

community hospital-based Continuing Medical Education program, will be compiled. This manual is the main objective for the next year's efforts.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the report of our Council on Medical Education. We note with gratitude the extensive work the council has done in organizing continuing medical education programs in Mississippi. We appreciate the chairman of the council appearing before our reference committee to discuss future activities of the council.

The report of the reference committee was adopted.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

The following amendment to the MSMA Constitution and By-Laws was presented in open session at the 105th Annual Session and officially sent to each component society two months prior to the 106th Annual Session as required by the Constitution and By-Laws. The proposed amendment would create an honorary membership category for laymen who have rendered "meritorious service."

Amend Article IV—MSMA Constitution Section 1. ". . . Members of the Mississippi State Medical Association. Members shall be active, associate, emeritus, or *honorary,* according to requirements and provisions of the By-Laws. There may also be invited guests. Membership other than associate *and honorary* shall be construed as active in connection with the rights and privileges accruing thereto. . . ." (New wording italicized)

Amend Chapter I—MSMA By-Laws Section 1. ". . . Eligibility. Each component society of the Mississippi State Medical Association shall judge the qualifications of candidates for election to membership therein, which shall be restricted to those persons who hold the degree of Doctor of Medicine from an appropriate accredited source as defined by the American Medical Association, or in lieu thereof, a foreign degree in medicine which is an acceptable equivalent to the Board of Trustees and shall be a citizen of the United States. All candidates for any degree of membership other than associate *or honorary* must be legally licensed to practice medicine in Mississippi. . . ." (New wording italicized)

Amend Chapter I—MSMA By-Laws Section 3 ". . . Degrees of Membership. Members of the Mississippi State Medical Association shall be divided into the following classifications (a) active . . . (b) associate . . . (c) emeritus . . . (d) *honorary membership. A layman who has rendered meritorious service may on approval and nomination by the judicial council be elected to honorary membership by majority vote of the House of Delegates. Honorary members shall not vote or hold office. . . .*" (New wording italicized)

Section 4 ". . . Registration Privileges. Only the following shall be permitted to register at any session:

(a) Active members
(b) Emeritus members
(c) Associate members
(d) *Honorary members*
(e) Invited guests
(f) Medical students of American Medical Association approved medical schools who are certified to the executive secretary of the association by their respective deans.
(g) Interns and residents who are graduates of American Medical Association approved medical schools and who are connected with an approved hospital and who are certified to the executive secretary of the association by their respective hospital superintendents in the event they are not associate members of the association.
(h) Commissioned medical officers of the United States Armed Forces who are on active duty and who if not associate members are certified to the executive secretary by their post or base surgeons. . . ." (New wording italicized)

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

This amendment to the MSMA Constitution and By-Laws would establish a category of honorary membership and was proposed by this House of Delegates last year to lie on the table until this 106th Annual Session. The proposed amendment has been furnished to all component societies as required by the Constitution and By-Laws. We recommend the adoption of the Report of the Council on Constitution and By-Laws.

The report of the reference committee was adopted.

(Turn to page 365)

New York is a vertigo festival.

Antivert®/25
(25 mg. meclizine HCl) Tablets
for vertigo*

Antivert® (meclizine HCl) has been found useful in the management of vertigo associated with diseases affecting the vestibular system. It is available as Antivert/25 (25 mg. meclizine HCl) and Antivert (12.5 mg. meclizine HCl) scored tablets for convenience and flexibility of dosage. Antivert/25 (25 mg. meclizine HCl) Chewable Tablets are available for the management of nausea, vomiting, and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

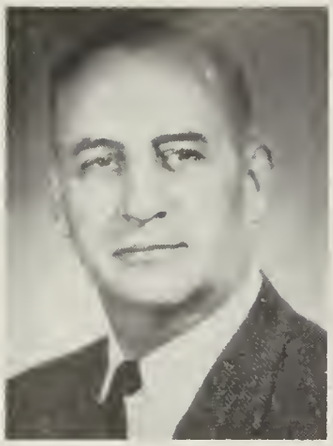
Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



The President Speaking

"The AMA Meeting"

J. T. DAVIS, M.D.
Corinth, Mississippi

I HAVE JUST returned from my official visit to Chicago and the annual session of the American Medical Association—my first in over 10 years. Truly it was a very colorful and eventful occasion for me.

Chicago's McCormick Place was filled to capacity with a multitude of exhibits—comprehensive scientific displays representing all disciplines of the medical profession and commercial exhibits from all parts of the U. S. The booth of the AMA was most interesting; it depicted the remarkable range of tangible benefits and services for the membership, e.g. insurance programs, attractive retirement programs, physician placement service, scientific specialty journals and the weekly American Medical News with the latest nonscientific news in medicine. Authoritative legal information as well as professional management information and guides for members' practice of medicine are provided on request.

The AMA Division of Scientific Activities gathers and disseminates information to the medical profession concerning drugs, foods and nutrition and cosmetics, occupational health hazards, safety guidelines in industry and many other areas. I was greatly impressed. Just to be a small part of such a great national organization made me proud.

The House of Delegates, where I spent a part of each day observing our national leaders in action, proved most interesting. As though prophesying the events to follow, the meeting of the House of Delegates opened with a colorful demonstration, re-enacting the events leading up to the American Revolution of 1776. Although there was much tension, emotions and anticipation of a revolution on the floor of the House as the many subjects and controversies were debated, the speaker never lost control and the proceedings generally were orderly. Even the smallest voice was heard. The House of Delegates, reference committee hearings, committee reports and election of officers all reflected the true democratic process at work. Even the controversial PSRO issue was settled in an orderly manner with the House of Delegates adopting the recommendation that PSRO be implemented in the respective states and improved by amendments with repeal being sought if this failed. This is similar to the recommendation adopted by the MSMA House of Delegates on May 9, 1974, and is now considered the most logical approach to the problem.

Recognizing the many advantages of membership and cognizant of the fact that the AMA continues to stand as a bulwark of strength both professionally and politically upon which we as members must depend for representation at the national level, the association merits our wholehearted support. ★★★

JOURNAL OF THE
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EDITORIALS

Carcinoma of the Stomach

HISTORY

In 1881 Billroth did the first successful gastric resection for carcinoma of the stomach. The operation performed was a resection with gastroduodenostomy, now known as a Billroth I resection. The patient survived the operation but died four months later from metastasis. In 1893 Roentgen discovered x-ray. By 1911 the x-ray diagnosis of carcinoma of the stomach had been well established.

INCIDENCE

Nine per cent of all cancer deaths are due to gastric carcinoma.

ETIOLOGY

The etiology of carcinoma of the stomach is unknown but certain factors may have a bearing on the disease. Heredity seems to play some part in the development of gastric carcinoma. Patients who have had a positive familial history of carcinoma of the stomach are twice as likely to develop gastric malignancy than those patients with a negative familial history. Race seems to have some bearing on the development of carcinoma of the stomach. The incidence is high in the Japanese race. This has been thought to be due to a low vitamin B_1 intake and recently there has developed a theory that the substance used to polish rice may contribute to the development of carcinoma. Apparently this is some form of talc which may cause gastric irritation. It is known that carcinoma of the stomach is higher in patients with achlorhydria. The incidence is higher in patients with pernicious anemia. Patients with little or no acid in the stomach are six times more likely to develop carcinoma than those with normal acid. Chronic gastritis may contribute to the development of cancer.

PATHOLOGY

Forty per cent of gastric carcinomas occur in the prepyloric region of the stomach. Twenty per cent occur in the lesser curvature. Ten per cent occur in the cardia; five per cent in the fundus; and only four per cent on the greater curvature side of the stomach. The prognosis in carcinoma of the stomach is fairly good in the bulky polypoid type. It is worse in the ulcerative or penetrating lesions, and dismal in infiltrating carcinoma.

PROGNOSIS

Patients with positive lymph node metastasis have an eight per cent 10-year survival. Those with negative regional lymph nodes have a 35 per cent 10-year survival.

DIAGNOSIS

The earlier a lesion is diagnosed, the better is the chance of cure. This means that a physician seeing patients with gastric symptoms must have a high index of suspicion for carcinoma. Upper G.I. x-ray is the most valuable diagnostic aid. Gastroscopic examination with biopsy, using the flexible fiberoptic gastroscope in combination with actual biopsy or brush biopsy, has been a great aid in the early diagnosis of carcinoma.

It is usually impossible to tell by looking at a gas-

tric lesion whether it is benign or malignant. It is a well known fact that serial sections around the edge of a gastric ulceration may show some areas of benign ulceration, while other areas may show malignant change.

The greatest controversy in carcinoma of the stomach concerns the ulcer-cancer problem. Ten to 15 per cent of gastric ulcers which were thought to be benign on gross inspection prove to be malignant on microscopic examination. However, of this number, 54 per cent demonstrated no metastasis. Whereas, of those that were operated upon for apparent carcinomas, only 28 per cent had not metastasized. Thus, approximately 80 per cent of the patients in the ulcer group would receive a curative type of resection as opposed to only 43 per cent in the group preoperatively diagnosed as cancer.

Any patient with gastric ulceration should be hospitalized for intensive medical therapy. If there is not complete healing of the lesion within 10 days, using all criteria, including x-ray and gastroscopic examination, the patient should then be explored and the ulcer excised for microscopic study. The fact that a gastroscopic brush biopsy or even a cup biopsy has been reported as negative for malignancy does not preclude the fact that there may be malignant changes in the ulcer not accessible to the biopsy forceps.

TREATMENT

The only cure for carcinoma of the stomach is surgical excision beyond all local and lymphatic spread. Of all gastric carcinomas, 40 per cent are inoperable at the time they are seen by the physician. Of the 60 per cent found to be operable, only 35 per cent will be resectable. The 10-year cure rate is 35 per cent in those patients with negative lymph node metastasis and eight per cent 10-year survival in those with positive regional lymph nodes.

PALLIATION

Palliative resection may be occasionally indicated to stop hemorrhage. In some instances a gastroenterostomy is done to relieve obstruction. But neither of these procedures improves the longevity of the patient to any extent. The average survival following palliative procedure is about three months. X-ray therapy for carcinoma of the stomach has not proven to be of any great benefit but may be helpful in certain types of gastric lymphomas, such as Hodgkin's disease. Chemotherapy has been used in certain cases, especially the lymphoma group, but chemotherapy for adenocarcinoma of the stomach has been a dismal failure.

SUMMARY

A high index of suspicion for carcinoma must be maintained in any patient with gastric symptoms. Upper G.I. series showing gastric ulceration should be an indication for intensive medical therapy of short duration, combined with gastroscopic examination and biopsy. If there is failure of complete healing in 10 days, in spite of negative gastroscopic biopsy, one must consider exploration and excision of the gastric ulcer for microscopic study. Only by adequate resection of very early lesions can we hope to improve the survival rate for carcinoma of the stomach.

George H. Martin, M.D.
Associate Editor
Vicksburg, Miss.

Medico-Legal Briefs

VIEWPOINT OF A PHYSICIAN'S ATTORNEY

JOHN F. KING

Malpractice cases against physicians have a common denominator—an element of blackmail.

Aggrieved patients often are encouraged by counsel to file suit, in many cases without discussions of the medical aspects of the problem. Medical investigation frequently is not made before broad, sweeping charges are alleged of recklessness, carelessness and wanton disregard, concluding with a damage claim in an outrageous amount.

The spirit of blackmail pervades these negotiations which thereafter ensue in an effort to settle the case. The plaintiff's attorney, encouraged by jury verdicts, has come to the conclusion that a physician is a "target defendant" against whom greater damages are recoverable than if he were just an ordinary tort defendant. An accident which causes a 10

John F. King, partner, Anderson, Coe & King, Baltimore, Md., law firm, is a prominent Maryland defense attorney. Mr. King is a director of the Medical-Legal Foundation of Maryland and a past chairman of the Maryland State Bar Association's Medical-Legal Committee. He is a member of the American Bar Association, the American Judicature Society and a director of the American Civil Liberties Union, Maryland Chapter. Mr. King serves as counsel for The Medical and Chirurgical Faculty of Maryland and The Baltimore City Medical Society.

per cent loss of use of a leg, for instance, would have a value in an ordinary tort case of perhaps $2,500 to $5,000; the same disability in negotiations to settle a malpractice case would have a value of $15,000 to $20,000.

What is traded on in these negotiations is not the principle of compensation to the injured patient, but the principle of "certainly the doctor does not want this case aired in a public forum." This approach does not encourage settlement. When the doctor senses himself to be thus challenged he often insists on defending a case which otherwise may have been reasonably and quickly settled.

The physician does not understand the present adversary court procedure and views it as an assault on his professional integrity. This feeling is reinforced by protraction of litigations, being harassed by multitudinous interrogatories which from his point of view have no bearing whatever on the medical understanding of the case, and depositions in the unavoidably hostile environment of counsel's office where he is subjected to protracted and often irrelevant haranguing.

Throughout these proceedings the physician gradually comes to the realistic view that the plaintiff attorney's purpose is not to develop the truth but to win the case, or at least to harass him to the point that his will to defend yields to demands for settlement.

Rather than have these adversary machinations result in a bitter settlement or hostile trial, how much more reasonable it would be for the patient to have the defendant physicians confer with the patient's "expert" so that both parties would develop a more objective evaluation of their medical positions. The case may thus be objectively evaluated and amicably disposed of by dismissal or settlement.

One obstacle is greed. The source of this greed is not only in the litigant-patient, but also in the counsel contingency fee practice. This evil should be abolished or severely restricted. It is not permitted in either Great Britain or Canada where there are no indications that aggrieved patients are unable to obtain competent counsel.

The physician is searching for a more effective way to deal with the problem. Should he not attempt to turn his patient and himself away from the court system with its adversary-jury features to the concept of arbitration? Arbitration has been adapted and proved effective in labor/management disputes where it was invoked to achieve faster and fairer dispositions.

The physician likewise should now employ the arbitration agreement approach in his pursuit of rapport with his patient. An arbitration agreement openly entered into at the outset of treatment can achieve a good result in this relationship for both parties.

Where arbitration has been employed there has been no sufficient change in the frequency of claims. The value of arbitration lies in its capacity to reduce the time and money it takes to dispose of claims.

The current litigation system with its implicit blackmail, necessary adversity, and mounting costs is no longer a feasible mechanism for resolving medical disputes to the satisfaction of either the doctor or his patient. Arbitration may be the answer. It certainly deserves a try.

(Reprinted from *St. Paul Co. Malpractice Digest*)

DEATHS

FRANKS, VICTOR DAVIS, Marks. M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1915; member of the Fifty Year Club MSMA; died June 11, 1973, age 83.

PERSONALS

ZED AYDELOTT, JR., has recently opened his office at the Professional Building, 1505 W. Quitman Street in Iuka for the general practice of medicine.

HELEN B. BARNES of Jackson and UMC was a guest speaker before the Georgia State Medical Society at Hilton Head, S. C.

WARREN BELL of Jackson and UMC was guest speaker on cancer chemotherapy at the annual meeting of the Hinds County Unit of the Mississippi Division of the American Cancer Society.

RICHARD C. BORONOW of Jackson and UMC spoke at the annual scientific meeting of Felix Rutledge Society in Memphis.

ARTHUR BOYD, formerly of Bluntville, Tenn., has set up a family practice at Sardis in the medical building adjacent to the hospital.

RONALD T. BRUNI announces the removal of his office for the practice of pediatrics to 0450 Pass Road in Gulfport in association with JAMES A. SHEFFIELD.

Richard G. Burman of Gulfport is serving as chairman of the American Association of Medical Assistants national advisory board.

Carlos M. Chavez of Jackson and UMC attended the International Cardiovascular Society seminar in Chicago in June.

Robert D. Currier of Jackson and UMC attended the combined meetings of the American Neurological Association and the British Neurological Association held in Boston.

Charles Farmer of Jackson is serving as president of the Hinds County Unit of the Mississippi Division of the American Cancer Society. Medical members of the board are Tate Thigpen, Frank Banks, Frank Howell, and B. T. Hickman, all of Jackson.

George C. Hamilton of Jackson was installed as a Fellow of the American Psychiatric Association at the association's annual meeting in Detroit in May.

Abdelkaer Hassen of Jordan and Loreta Villaneuva of the Philippines have joined the staff of Charity Hospital in Natchez.

Donald T. Imrie of Vicksburg has accepted a post as fulltime clinical professor of orthopaedic surgery at the University of Mississippi School of Medicine in Jackson.

G. Gordon McHardy of Pass Christian was named a Master of the American College of Physicians by the Board of Regents at the convocation program in New York City.

Bruce M. McCarthy and Benjamin M. Carmichael have joined the staff of the Hattiesburg Clinic Professional Association. Dr. McCarthy is in the practice of orthopedic surgery and Dr. Carmichael is in internal medicine and cardiology.

Francis Morrison of Jackson and UMC attended the Council of Community Blood Banks meeting at Vail, Colo., in June.

Bernard S. Patrick of Jackson and UMC attended the Foundation for International Education in Neurological Surgery board meeting in Washington, D. C. Dr. Patrick is treasurer of the board.

Curtis Roberts of Brandon was presented a certificate in Washington, D. C., by the Society of United States Air Force Surgeons. He was named Command Flight Surgeon of the Year for the Air National Guard.

Philip W. Rogers has recently joined the staff of the Hattiesburg Clinic as nephrologist. He is a graduate of the LSU School of Medicine.

Leo J. Scanlon of Vicksburg attended the Tufts University School of Medicine course in gross and microscopic pathology of the skin held at Boston.

Donald M. Sherline of Jackson and UMC conducted residency review in ob-gyn at Tupelo June 4.

W. W. Strange of Booneville was honored by the Northeast Mississippi hospital for 50 years of dedicated service to the medical profession.

James F. Suess of Jackson and UMC participated in conferences and round table discussions at the AMA annual convention held in Chicago during June.

Joe Wayne Walker of Water Valley has been notified that he has been elected to appear in the 1974 edition of *Who's Who in Mississippi.*

John Knox Wilson, formerly of Raleigh, has set up practice at Colonial Plaza in Gulfport.

William L. Wood, Jr., of Tupelo was elected president of the Mississippi Heart Association at the annual assembly in Jackson.

Twenty-six Students Participate in MECO

Twenty-six University of Mississippi School of Medicine students are finding out for themselves what community health care is all about.

This summer they're getting first-hand experience in 10-week assignments at 19 hospitals across the state participating in Medical Education and Community Orientation (MECO).

MECO is a cooperative project with community hospitals and physicians which puts medical students on the front line of health care while they're still in school.

Sponsored in Mississippi by the University chapter of the Student American Medical Association, Mississippi Hospital Association, and Mississippi State Medical Association, MECO began in Illinois seven years ago and has spread to a number of states with hundreds of students, physicians, and hospitals participating. This is MECO's fourth summer in Mississippi.

THE LITERATURE

Book Review

The Immediate Care of the Acutely Ill and Injured. Edited by Hugh E. Stephenson, Jr., M.D., F.A.C.S. 251 pages. St. Louis: The C. V. Mosby Company, 1974. $7.50 for the paperback edition.

Dr. Stephenson is to be commended for editing this book which gives the best known methods of immediate treatment of the acutely ill and injured. He has selected well qualified contributors in all fields of medicine where emergency treatment is necessary.

In an effort not to overlap with other areas of the medical curriculum, the inclusion of material concerning definitive care beyond the immediate or emergency stage has been avoided. Therefore a condensed book containing only 251 pages has been published.

The major stimulus for writing this book was for medical students interested in the subject of immediate care of the acutely ill and injured. This has been offered as an elective course for freshmen medical students at the University of Missouri and nearly 100 per cent of the classes take the course.

Many distinguished and outstanding physicians contributed to this book.

I recommend this book to any doctor, nurse, and/or paramedical personnel working in an emergency area. The book is very easy to read. It would be a good idea to have a copy of this book in the emergency room of all hospitals for quick reference. This is a good book for all M.D.'s to read regardless of their specialty. In addition to methods of immediate treatment for emergencies in his own field, a disaster could occur when a doctor might be called upon to render life saving treatment in other fields. Dr. Robert H. Kennedy stated in the book that first year medical students wanted to take the course so that when they went home for Christmas they would know a little more about first aid than a well trained Boy Scout. The doctor who hasn't read a recent book on cardiopulmonary resuscitation might be embarrassed to find that he doesn't know as much about first aid as a well trained Boy Scout. I think reading Dr. Stephenson's book would help bring us up to date.

JAMES E. BOOTH, M.D.
Eupora, Miss.

Southeastern Internists Will Meet in October

Specialists in internal medicine and related medical fields will hold a three-day scientific meeting on Oct. 10-12, 1974, at The Mills Hyatt House in Charleston, S. C. The states included in the meeting are Alabama, Georgia, Louisiana, Mississippi, and South Carolina.

The Southeastern Regional Meeting of the American College of Physicians (ACP) is designed to bring physicians up-to-date on late developments in the field of internal medicine. It is one of more than 30 such sessions held each year throughout the United States, Canada and Mexico by the 26,500-member medical specialty society.

One of the prime purposes of the American College of Physicians, which is headquartered in Philadelphia, Pa., is the continuing education of practicing physicians. In addition to regional meetings, it sponsors a four-day national meeting and postgraduate courses, and publishes the monthly *Annals of Internal Medicine*.

In charge of arrangements for the ACP Southeastern Regional Meeting is Dr. Roy A. Howell, Jr., Bennettsville, S. C., who serves as the ACP's representative for the state of South Carolina.

NEW MEMBERS

CROCKER, CHARLES HAWKINS, Bruce. Born Bruce, Miss., Feb. 12, 1940; M.D., Tulane University School of Medicine, New Orleans, La., 1964; interned Charity Hospital, New Orleans, La., one year; residency in surgery, City of Memphis Hospitals, Memphis, Tenn., 1965-69; elected by Northeast Mississippi Medical Society.

MORRIS, TOXEY M., Hattiesburg. Born Hattiesburg, Miss., Sept. 27, 1938; M.D., Tulane University School of Medicine, New Orleans, La., 1963; interned Confederate Memorial Medical Center, Shreveport, La., one year; residency in surgery,

same, one year; urology residency, UMC, Jackson, Miss., 1968-71; elected by South Mississippi Medical Society.

TIMMER, GERARD JOHANNES, Philadelphia. Born Djakarta, Indonesia, Jan. 12, 1913; M.D., University of Amsterdam, Netherlands, 1941; elected to Associate membership by East Mississippi Medical Society.

WELCH, CARL CHAPMAN, Corinth; Born Raymond, Miss., Dec. 2, 1931; M.D., University of Arkansas School of Medicine, Little Rock, Ark., 1968; interned, same, one year; pathology residency, same, 1969-71; elected by Northeast Mississippi Medical Society.

POSTGRADUATE CALENDAR

Sept. 30-Oct. 4

ELECTROCARDIOGRAPHY INTENSIVE COURSE

University Medical Center, Jackson

Sept. 30-Oct. 1-4, 1974, beginning at 9:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

Thomas M. Blake, M.D., professor of medicine, the University of Mississippi School of Medicine

Selected for their immediate applicability, topics in this one-week course will be supplemented by use of electrocardiograms, slides, and other visual aids. The course will emphasize the interpretation of tracings as an important and integral part of the work. Participants will interpret electrocardiograms and join in conferences.

Oct. 28-Nov. 1

NEUROLOGY AND NEUROSURGERY INTENSIVE COURSE

University Medical Center, Jackson

Oct. 28-31, Nov. 1, 1974, beginning at 8:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinators:

Robert C. Currier, M.D., professor of medicine, the University of Mississippi School of Medicine, and co-director of the stroke unit of the Regional Medical Program

Armin Haerer, M.D., associate professor of medicine, the University of Mississippi School of Medicine

The content of this course will include the management of adult and children's neurological disorders. Material will be presented in seminars, discussion groups and assigned reading and rounds on the wards and clinics. Rehabilitation techniques will be included.

Nov. 4-8, 1974

UROLOGY INTENSIVE COURSE

University Medical Center, Jackson

Nov. 4-8, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

W. Lamar Weems, M.D., associate professor of surgery and director of division of urology, the University of Mississippi School of Medicine

The emphasis of this course will be on practical urology as it relates to the nonurologist. The latest concepts and practices in common urologic diseases will be presented.

Nov. 18-22, 1974

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson

Nov. 18-22, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:

John D. Bower, M.D., associate professor of medicine and director of the artificial kidney unit, the University of Mississippi School of Medicine

In this clinically oriented course, emphasis will be placed on reversible and treatable forms of kidney disease. The management of acute kidney failure and control of reversible features of chronic kidney disease will be presented in depth.

Tentatively scheduled are one-week intensive courses in EKG, radiology, pulmonary medicine, ENT, hematology, cardiology, newborn, and pediatrics.

All intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, pharmaceutical firms, volunteer health agencies, and private donation. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged.

College of Surgeons Plans 60th Annual Meet

The world's largest meeting of surgeons, the 60th annual Clinical Congress of the American College of Surgeons, will be held in Miami Beach, Fla., Oct. 21-25.

The meeting will be the first to be held in the newly-expanded Miami Beach Convention Center now nearing completion.

Close to 25,000 surgeons, guests, exhibitors and members of other medical disciplines are expected to attend.

One of the highlights of the Congress will be the computerized mini-SESAP II exhibit. SESAP is the college's Surgical Education and Self-Assessment Program. Close to 15,000 surgeons took the SESAP I assessment, made available in 1971. Enrollment for SESAP II began in June, and materials will be distributed in October. The mini-SESAP exhibit at the Clinical Congress will contain 100 desks and a computer terminal. Visitors will be able to take a sample assessment of 15 questions (out of 751). By means of the computer, the answers can be scored and evaluated, and the participant informed of his or her standing—all in a matter of seconds.

In addition to specific lectures in every area of surgery, and postgraduate courses, there will be general sessions on such subjects as cancer therapy, obesity, trauma, surgical undergraduate teaching as viewed by non-surgeons, surgical ethics, professional standards review organizations, financing surgical care throughout the world, and the influence of surgical systems on surgical care.

Medical Center Announces Promotions

Dr. Harold B. White, Jr., has been named director of learning resources at the University of Mississippi Medical Center and Dr. Richard C. Miller associate dean of the School of Medicine, according to Vice Chancellor Dr. Norman C. Nelson.

In other medical school faculty changes, eight moved to the rank of professor and 11 to the associate professor level. Seven others became assistant professors.

Dr. Carl G. Evers, associate dean for student affairs, and Dr. Julius Major Cruse are professors of pathology. Professors of psychiatry are Dr. David H. Barlow and Dr. Edward B. Blanchard. Others who are full professors are Dr. Guy D. Campbell, medicine; Dr. Donald T. Imrie, orthopedic surgery; Dr. Jose M. Montalvo, pediatrics; and Dr. James B. Grogan, surgery.

Those who attained the rank of associate professor include Dr. Myron W. Lockey, surgery; Dr. Virginia Read, biochemistry; Dr. Martin H. Steinberg, medicine; Dr. Dennis O'Callaghan, microbiology; Dr. Helen Barnes, ob-gyn; Dr. Asa T. Klein, pharmacology; Dr. Harris J. Granger and Dr. Robert E. McCaa, physiology-biophysics; and Dr. Gene Abel, Dr. Richard M. Eisler, and Dr. Peter M. Miller, psychiatry.

Named assistant professors are Dr. Thomas E. Freeland, family medicine, who is dean of the School of Health Related Professions; Dr. Jean Arceneaux, microbiology; Dr. Albert W. Conerly, medicine; Dr. David B. Noble, Dr. David B. Young, and Dr. David H. Pearce, physiology-biophysics; and Dr. Donald M. Sherline, anesthesiology.

Controlled Substances Act Changes Announced

The State Board of Health in regular session on Dec. 7, 1973, effected changes in schedules of various drugs of the Mississippi Controlled Substances Act.

The drug METHAQUALONE (Quaalude) was changed from Schedule III to Schedule II of the Federal Controlled Substances Act effective Nov. 5, 1973. Although discussion was held and action taken to effect this change in the Mississippi Controlled Substances Act, inadvertently this action was not included in the minutes of the State Board of Health in regular session on Dec. 7, 1973.

Excerpt from minutes of the State Board of Health in regular session on June 20, 1974:

"Motion was made by Dr. Moncure Dabney, seconded by Dr. John Egger, and passed, that since the Board in regular session on Dec. 7, 1973, voted to change METHAQUALONE (Quaalude) from Schedule III to Schedule II of the Mississippi Controlled Substances Act effective Nov. 5, 1973, and the action was inadvertently not included in the minutes of that meeting, the Executive Officer be instructed to include this change as part of the minutes of the meeting on Dec. 7, 1973."

UMC Family Medicine Residencies Grow

More family medicine residencies are available at the University of Mississippi Medical Center than at most other medical schools in the nation.

The Residency Review Committee for Family Practice of the AMA approved 12 more first-year positions for the Medical Center department, according to Dr. W. R. Gillis, chairman of the department. This brings to 16 the number of young physicians in the program as of July 1, 1974.

Most of the newly approved programs have three or four slots for each of the three training years with the Mississippi institution and Grace Hospital in Detroit, an affiliate of Wayne State University, the only two with more than 10.

Projections are that by 1976 at least 36 residents will be in the Mississippi program.

During their three-year training program, UMC family medicine residents serve as primary care physicians in a realistic practice environment, in addition to service in traditional teaching areas. They get experience in both the model practice facility of the department and in satellite teaching centers throughout the state.

Medical Assistants Seek National Week

The American Association of Medical Assistants has requested assistance in achieving passage of The H. J. Resolution 939 which has now been referred to the Judiciary Committee of the U. S. House of Representatives.

The resolution reads as follows:

JOINT RESOLUTION

To designate the third week of September "National Medical Assistants' Week."

WHEREAS, Medical assistants provide invaluable assistance to the physicians of this country; and

WHEREAS, Their services help to insure that adequate medical care is available for citizens of this country; and

WHEREAS, Recognition should be given to the devotion with which these individuals perform their duties; now, therefore, be it

Resolved, By the Senate and House of Representatives of the United States of America in Congress assembled, that the third week of September of each year is designated as "National Medical Assistants' Week"; and the President of the United States is authorized and requested to issue a proclamation calling upon the people of the United States and interested groups and organizations to observe that day with appropriate ceremonies and activities.

Southern MDs Team Up to Improve Health Care



University of Mississippi Medical Center pediatric cardiologists were on call for any newborn cardiovascular problems that might arise while University of Alabama Medical Center at Birmingham physicians were attending a meeting in Europe. When a "blue baby" was born there, a National Guard helicopter transported him to the Jackson campus where pediatric cardiologists cared for him until his own physicians returned. Such teamwork is the goal of the Southern Perinatal Association, a 14-state cooperative venture which emphasizes regional centers to improve and expand health care for mothers and babies and to reduce the South's staggering maternal/infant death rate.

Journal MSMA Visits the AMA

by NOLA GIBSON and CHARLES MATHEWS

An address by Vice-President Gerald Ford, a change in the method of electing AMA Trustees, a definitive policy statement on PSROs, the need for additional safeguards to preserve the confidentiality of medical records, new recommendations which affect the relationship between hospitals and hospital medical staffs, and contractural relations of housestaffs were among the important items before Delegates at the 123rd Annual AMA Convention in Chicago. It all made for what observers called "a historic meeting" and the JOURNAL MSMA was there!



MSMA Delegates to the AMA Drs. G. Swink Hicks of Natchez and Joseph B. Rogers of Oxford are shown at their seats in the House of Delegates (second row, seated third and fourth from right).

Vice-President Ford advocated passage of a national health insurance program this year building on private and voluntary mechanisms. He warned of a possible "veto proof" Congress next year.

The House approved bylaws changes that replace the "slot method" of electing trustees by the "simultaneous election of candidates to several positions of equal rank," in which all candidates run for board vacancies on a single ballot.

Under the new method, trustees for full, three-year terms are elected first, followed by the selection of trustees to fill unexpired terms. Election of the AMA president-elect, vice-president, and speaker

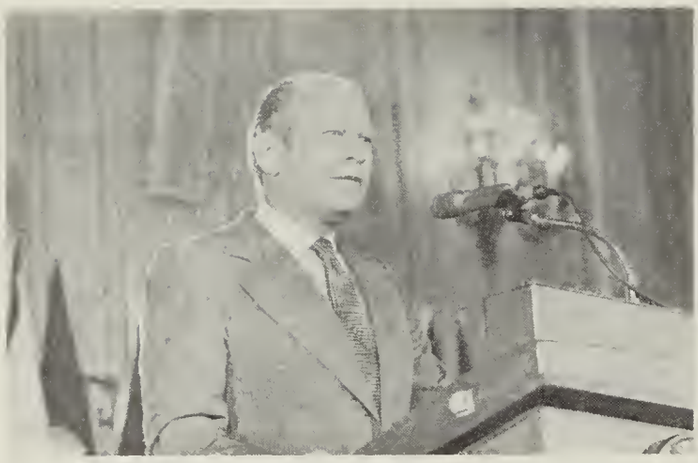


Outside the AMA House of Delegates awaiting the arrival of Vice-President Gerald Ford, MSMA Alternate Delegate to the AMA Dr. Stanley A. Hill (right) is shown chatting with AMPAC Director William F. Watson.

and vice-speaker of the House remains on a separate basis.



A large audience was present at the AMA Reference Committee considering the numerous reports and resolutions on PSRO.



Vice-President Gerald Ford is shown addressing the AMA House of Delegates at the Palmer House in Chicago.



AMA President Malcolm C. Todd was inaugurated at ceremonies on June 26. In the background are the flags of the states and territories which compose the AMA.

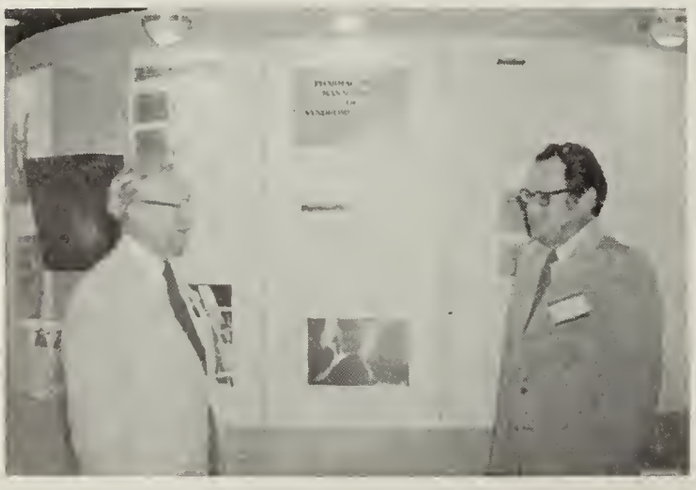
In a close vote, Delegates selected Dr. Max Parrott of Portland, Oregon, as president-elect by a vote of 121-119 over Dr. Richard S. Wilbur, former AMA Deputy Vice-President. In addition to Dr. Parrott, others elected or re-elected to positions in the association were: Dr. Joseph M. Ribar, Alaska, Vice-President; Dr. Tom E. Nesbit, Tennessee, Speaker of the House (re-elected); Dr. William Y. Rial, Pennsylvania, Vice-Speaker of the House (re-elected); Dr. Daniel Cloud, Arizona; Dr. James M. Blake, New York; Dr. Hoyt D. Gardner, Kentucky; Dr. Raymond T. Holden, District of Columbia (re-elected), Trustee for three-year terms; and Frank J. Jirka, Illinois, and Joe T. Nelson, Texas, Trustees for unexpired terms. Two incumbent trustees failed to be re-elected. They were Dr. John M. Chenault, Alabama, Vice Chairman of the Board, and Dr. Donald E. Wood, Indiana.

Speculation over possible changes in PSRO policy by the House dominated the attention of those attending the convention, including the media. During its day-long hearing on Monday, June 24, Reference Committee A considered two reports and 25 resolutions bearing on the issue. An estimated 64 speakers addressed themselves to PSRO.

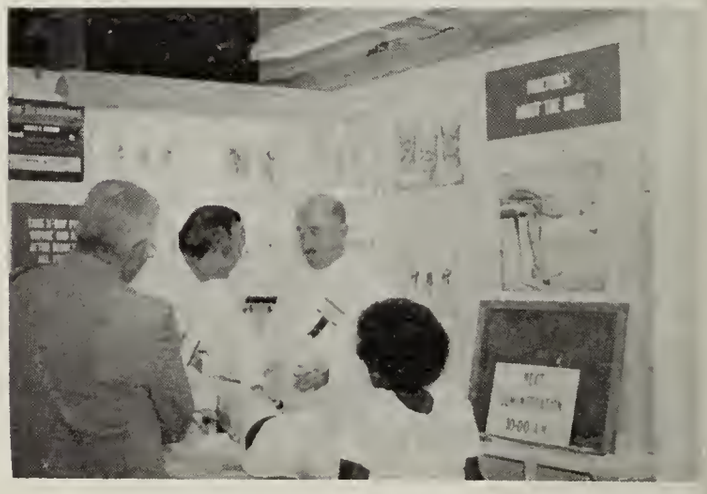
But on Wednesday, the Delegates—perhaps cognizant of the hours of debate devoted to PSRO at Anaheim last December and in New York City last June—overwhelmingly voted (202 to 24) to terminate debate after a few minutes.

Then the House adopted a substitute resolution on PSRO proposed by the reference committee whose members emphasized that the resolution provides the association with a "clear-cut, definitive position which cannot be misunderstood by anyone inside or outside this House of Delegates." The resolution:

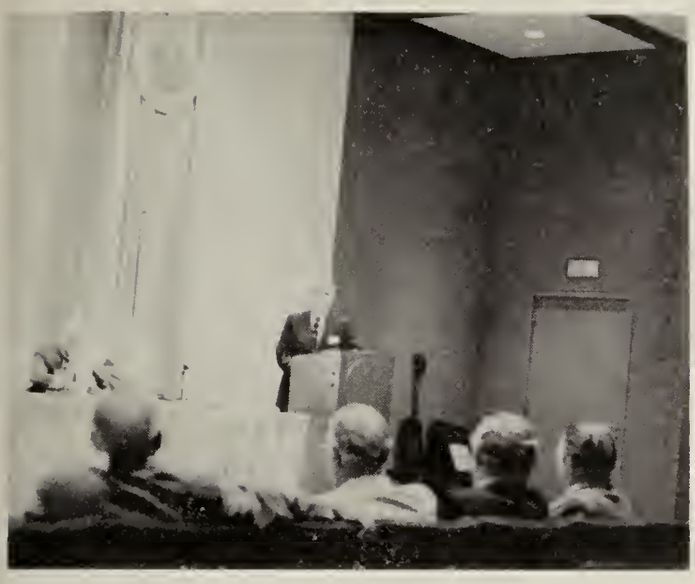
—Instructs the Board of Trustees to seek con-



MSMA President Dr. J. T. Davis is shown at the AMA scientific section chatting with fellow Mississippian Dr. Lawrence H. Brisco of Tupelo.



Pictured is one of the many "live" exhibits at the AMA scientific section. This one is on "Fractures About the Knee."



Dr. James D. Hardy, University Medical Center Professor and Chairman of Surgery, was a guest speaker before the AMA Surgical Section. Dr. Hardy discussed endocrine emergencies in surgery.



Among the many Mississippians visiting the AMA meeting were Dr. and Mrs. David L. Clippinger of Gulfport shown here at the AMA scientific section, in McCormick Place.

structive amendments to the PSRO program, particularly in potentially dangerous areas such as confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW.

—Directs the AMA to continue efforts to achieve legislation which allows the profession to perform peer review according to established medical philosophy and the best interests of the patient.

—Emphasizes that state associations which elect non-compliance with PSRO are not prevented from doing so by the new policy, but urges such associations to develop effective non-PSRO review programs embodying the principles endorsed by the profession as constructive PSRO alternatives.

The new policy also provides that in the event that the PSRO program does, in fact, adversely affect patient care or conflict with AMA policy, then "the Board of Trustees (will) be instructed to use all legal and legislative means to rectify these shortcomings."

The House adopted two reports bearing on confidentiality of medical records. Report I of the Council on Medical Service describes a wide-ranging series of proposals to enable the medical profession and insurance companies to "maintain the confidentiality and security of patient information." Report S of the Board of Trustees notes that the Council on Legislation is developing model legislation as a guide to possible state legislation to preserve confidentiality, and that a model bill should be ready for consideration by the House at the 1974 Clinical Session in Portland, Oregon.

The House adopted the 104 page "Report on Physician-Hospital Relations, 1974," compiled by the Council on Medical Service and its Committee on Private Practice. An update of an earlier report made in 1964, the 1974 version contains 14 specific recommendations to cope with problems developing between some hospitals and their medical staffs. Among other things, the recommendations are aimed at protecting medical staffs against unilateral action by hospital governing boards relative to staff bylaws, rules, and regulations. The report as adopted was presented to the MSMA House of Delegates at its meeting in May.

In other action, two informational reports dealing with possible guidelines for housestaffs in developing contracts in institutions in which they serve generated considerable discussion before Reference Committee C. Among those testifying were medical students, residents, faculty members, hospital directors, and members of the AMA's Board of Trustees and Council on Medical Service. After much discussion, the two reports, plus a revised report submitted by the Intern and Resident Business Session during the convention, were referred to the Board of Trustees for further study and consultation with appropriate groups. Delegates directed the Board to report back at the 1974 Clinical Session.

UMC Resident Receives SMA Research Grant

Dr. Peter A. Ward of the Department of Surgery at the University of Mississippi School of Medicine, Jackson, has been awarded a research project grant by Southern Medical Association (SMA).

The 22,000-member physician group annually supports medical research by awarding grants to initiate projects or continue relatively new studies.

Dr. Ward is one of 32 researchers, selected from more than 100 applicants, to receive an SMA research grant this year. The grant will help fund his project, Free Muscle Transfers Using Microneurovascular Anastomoses.

The Research Project Fund, established in 1969, is one of several SMA programs that support the organization's exclusive purpose of developing and fostering scientific medicine.

Based in Birmingham, Ala., Southern Medical Association is comprised of physicians from 16 states and the District of Columbia. The organization will hold its 68th Annual Scientific Meeting, the second largest conclave of medical science in the nation, in Atlanta, Nov. 17-20.

Chiropractic Manipulations Cause Strokes

Chiropractic adjustments of the head and neck are named as a cause of stroke and serious illness in a report in the July 8 issue of the *Journal of the American Medical Association.*

Robert G. Miller, M.D., and Robert Burton, M.D., of the Department of Neurology of the University of California School of Medicine at San Francisco report on treating two patients suffering from the after-effects of stroke induced by chiropractic manipulations.

The doctors also report that there are now a total of 12 reported cases of stroke related to chiropractic treatments.

A 52-year-old woman sought chiropractic manipulation for recurrent neck pain. During the treatment she developed dizziness, nausea and blurred vision. Then weakness and numbness on the left side developed. She was unable to stand when she sought help later from the neurologists. After five months of therapy she partially regained strength and coordination in the affected left side.

A 35-year-old former Air Force man suffered from similar symptoms after a chiropractic adjustment for an aching stiff neck. Although he lost consciousness during the first manipulation, a second treatment was administered. His memory suffered and he was unable to sit or stand.

After a year of neurological treatment, the patient still was severely handicapped by his intellectual deficit, had to sell two of his businesses, had several near accidents in his auto, and found a marked reduction in his aptitude in social situations.

In both cases, major brain damage could have been averted had the chiropractors stopped treatment immediately when the first symptoms appeared, say Drs. Miller and Burton. In neither case was the importance of the symptom complex appreciated by chiropractor or patient, they say.

UMC Offers Newborn Medicine Fellowship

The newborn center of the children's hospital at the University of Mississippi Medical Center in Jackson has received Maternal Child Health Services funds for a fellowship in newborn medicine.

Preferred starting date is July 1, and the stipend is $10,000 per year plus $500 for each dependent to a maximum of three.

Occupying the fourth floor of the children's hospital, designed in the round and opened in 1970, the newborn center nursery has 82 bassinettes, 48 for the newborn and 34 for various levels of intensive care.

Patients are inborn and outborn infants under one month of age who have both medical and surgical problems. Trainees benefit from participation in the evaluation and treatment of all types of problems occurring in the newborn period.

Working closely with the newborn center are the Department of Ob-Gyn and the Clinical Research Center. Additionally, the newborn center has a three-phased outreach program developed with the assistance of the Children's Bureau and the Mississippi Regional Medical Program.

Interested applicants should write Dr. Alfred W. Brann, Jr., Newborn Center Director, University Medical Center, 2500 North State Street, Jackson 39216.

(Continued from page 350)

REPORT OF THE BOARD OF TRUSTEES

Organization and Duties—The Board of Trustees is the executive and governing body of the association during vacation of the House of Delegates. It is additionally charged with the duties and responsibilities prescribed by law for directors of corporations. In the discharge of these duties, the Board shall have conducted four meetings during the 1973-74 association year consisting of seven meeting days. Eight officers sit with the Board of Trustees at all meetings. They are the president, president-elect, immediate past-president, secretary-treasurer, speaker, vice speaker, and the two AMA delegates.

This annual report includes actions on matters referred to the Board by the House of Delegates and items relating to the management and policy functions which are among the Board's responsibilities.

Referrals From the House of Delegates—Matters referred to the Board of Trustees at the 105th Annual Session, 1973, and actions by the House requiring further consideration and implementation include:

a. *Resolution No. 10*—This resolution concerning "Facts on the Health Care Economy" was adopted by the House of Delegates and distributed to each member of the association.

b. *Resolution No. 12*—This resolution concerning creation of a State Department of Mental Health with a physician director and strong physician representation on its governing board was adopted by the House of Delegates and is the subject of a report by the Board concerning 1974 legislative activities.

c. *Address of the President—Recommendations Nos. 1, 2, and 4 and Resolutions Nos. 2 and 11*—These several recommendations and resolutions dealing with composition, representation, and terms of office of the Board of Trustees were amended and adopted by the House of Delegates and referred to an *ad hoc* study committee to be appointed by the president. They are the subject of a special report to the House of Delegates by the Committee to Study Realignment of the Board of Trustees *(ad hoc)*.

d. *Address of the President—Recommendation No. 3*—This recommendation that the immediate past-president be invited to sit with the Board effective in 1974 was adopted by the House of Delegates effective 1973 and has been implemented.

e. *Honorary Membership Category*—Action by the House of Delegates to create an honorary membership category for laymen who have rendered meritorious service has been implemented and is the subject of a special report from the Council on Constitution and By-Laws.

f. *Expanded Role for the Nurse Practitioner*—Approval for the association to endorse and support necessary legislation to implement an expanded role for the qualified nurse has been implemented and is the subject of a report by the Board concerning 1974 legislative activities.

g. *Legislative Health Voting Index and Organization of Legislative Contact Committee*—Recommendation to establish a health voting index for each member of the 1972-76 Mississippi Legislature and to organize a legislative contact committee has been implemented and is the subject of a report by the Board concerning 1974 legislative activities.

Nominations for the State Board of Health—Based on action by the House of Delegates at the 1973 annual session, nominations for Mississippi State Board of Health Districts 1 and 3 for six-year terms beginning Jan. 1, 1974, were submitted to Governor William L. Waller. Governor Waller has made the following appointments in this regard: Public Health District 1, Dr. Benton M. Hilbun, Tupelo; Public Health District 3, Dr. John G. Egger, Drew. No vacancies will occur on the State Board of Health in 1974.

CHAMPUS—The association enters its 18th year as fiscal administrator for CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). An 11 member physician committee serves as the review committee for the program. During the past year the management and efficiency of this program as conducted by the association were cited. CHAMPUS continues to grow with an increase in claims volume of 1.5 per cent and a dollar volume increase of 16 per cent in 1973. During 1973 dependents of 100 per cent totally disabled veterans were included as beneficiaries of the program.

Insurance Programs—The association continues to sponsor a hospitalization group program with Blue Cross and Blue Shield of Mississippi, Inc., general accident, disability, health and life groups with the Continental Casualty Company, and a professional liability program with the St. Paul Companies. There are approximately 2,800 contracts among 1,400 MSMA members in the Blue Cross and Continental Casualty Company group plans and approximately 1,100 MSMA members participate in the

professional liability insurance program with the St. Paul Companies. The Board of Trustees annually reviews all programs.

The Continental Casualty Company group programs are administered by Thomas Yates and Company of Jackson. Improvements in these contracts during the year as announced to all MSMA members will include increases in the benefit levels provided under the disability income, hospital payment, excess major, and term life programs.

Budget and Finance—The Council on Budget and Finance met in November 1973 and prepared the 1974 budget which was presented to the Board in accordance with established procedure. The budget will be presented to the House of Delegates in the customary manner.

Legislative Program—The 1974 Regular Session of the Mississippi Legislature convened in Jackson on Jan. 8, 1974. The Council on Legislation held meetings prior to and during the session for purposes of organizing and monitoring the association's legislative program. Other activities have included production of the weekly legislative newsletter, continuation of the Emergency Medical Care Unit at the Capital, organization of a physicians' legislative contact committee and formulation of a "health voting index" on each member of the Mississippi Legislature.

The state medical association had a four point legislative program for the 1974 Regular Session based on prior actions of the House of Delegates: (1) State Medical Examiner Act; (2) health coverage for the newborn; (3) require uniform claim form for physicians' services, and (4) provide expanded role for RNs. The association also actively supported or opposed other legislative proposals before the 1974 Legislature. A full report will be made in this regard at the annual session.

Mississippi Foundation for Medical Care, Inc.—The Mississippi Foundation for Medical Care, Inc. was organized with the approval of the House of Delegates in 1971. As noted then, voluntary medical care foundations have such principal functions as: (1) to conduct peer review; (2) to provide for the medical profession assuming direct responsibility for and leadership in care delivery; and (3) to provide the most knowledgeable and capable source for (physicians') claims processing and payment information.

At the 1973 annual session the House of Delegates directed the MFMC to proceed to organize the Professional Standards Review Organization Program in Mississippi as required by Public Law 92-603 and within the context of the principles of the MFMC as voluntarily endorsed by its members. The House of Delegates further directed the MFMC to proceed to organize a review mechanism between third party payors and (MFMC) physicians accepting contractural assignments from such third parties. Based on these actions the MFMC has proceeded to develop a peer review plan and "Minimum Standards for Foundation-Endorsed Group Insurance Programs," the latter to cover both physicians' fees and benefit levels.

The MFMC will conduct an annual membership meeting in conjunction with the 106th Annual Session.

Experimental Medical Care Review Organization (EMCRO)—In 1971, the Mississippi State Medical Association received a grant award from the National Center for Health Services Research and Development, Department of Health, Education, and Welfare, to develop a physician sponsored system of evaluating the quality of medical care. The MSMA/EMCRO project will begin its fourth year of operation effective June 1, 1974. The following represents a summary of activities to be conducted by EMCRO during its fourth year:

(1) Test and demonstrate the interfacing of a total hospital care review system to include concurrent review, retrospective review, and continuing medical education;

(2) Continue development and refinement of system to evaluate skilled nursing home services;

(3) Continue development and refinement of a hospital emergency room services review system;

(4) Develop an ambulatory care review system as an extension of the EMCRO hospital and skilled nursing home services review systems; and

(5) Develop standards of patient outcome as method of evaluating health care quality.

Journal MSMA—The JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION concluded its 14th year of continuous publication with the 168th issue in December 1973. The thrust of the JOURNAL continues solidly around Mississippi medicine, the association, and the Mississippi physician.

Total pages in Volume XIV, 1973, were slightly down from 1972 due to a decline in advertising. Although advertising on a national level continues to

decline, a concerted effort has paid off in more local, instate ads for the JOURNAL. Editorial and scientific articles and personal news items on physicians increased during 1973 and two new monthly departments were added: (1) medico-legal briefs; and network for Continuing Medical Education television schedule.

Among other services the JOURNAL contributes to the association by publishing and absorbing costs are: complete program of the 106th Annual Session; handbook and proceedings of the House of Delegates; Constitution and By-Laws; regular listing of component medical society officers and meeting dates.

The Board wishes to acknowledge special appreciation to the editors and Committee on Publications in the production of this vital membership service. It is not accomplished without time, effort, and devotion.

MPAC—The Mississippi Medical Political Action Committee continues to enjoy the interest and support of Mississippi physicians. This year at the annual American Medical Association-American Medical Political Action Committee Public Affairs Workshop, the Mississippi Medical Political Action Committee received an award for its high percentage of eligible members. We urge continued participation in MPAC and AMPAC by all members.

MSMA-AMA Practice Management Workshop—In conjunction with the American Medical Association, the Board approved the conduct of a "practice management workshop for the new physician," Dec. 17-18, 1973, in Jackson. The program was enthusiastically received by the participants. The Board is investigating the possibility of continuing the workshop on an annual or biennial basis with the cooperation of the University of Mississippi School of Medicine and/or University of Mississippi Medical Alumni Association.

MSMA Membership Recruitment Program—Based on prior actions of the House of Delegates, the president, president-elect, vice presidents, and the Board have actively sought to build an effective membership recruitment program. This year the American Medical Association gave added impetus to the program by offering a recruitment bonus to the component medical society of the new AMA member consisting of one-half of the member's first year AMA dues. The Board is happy to note that there has been a numerical increase in both MSMA and AMA members exceeding the average annual increase in this regard. The association received an award for its increase in AMA members even preceding the new recruitment bonus program. We are hopeful for the future and plans are firm to continue our efforts in this regard.

Organization of the Board—One new Trustee, Dr. Robert S. Caldwell of Tupelo, District 3, was welcomed to the Board during 1973-74. Officers of the Board during the year are Drs. James O. Gilmore, Oxford, Chairman; Everett Crawford, Tylertown, Vice Chairman; and Gerald P. Gable, Hattiesburg, Secretary.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the annual report of our Board of Trustees. We are amazed at the growing amount of business handled by the board in our behalf. We wish to commend these men for the outstanding job they do.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT A OF THE BOARD OF TRUSTEES

Legislative Activities—Background. The 145th Session of the Legislature convened in Jackson on Jan. 8, 1974, for its third 90 day session of the 1972-76 term. The Council on Legislation held one meeting prior to the convening of the Legislature and reported to the Board of Trustees at its December meeting in this regard. The council also met regularly during the legislative session. In accordance with prior directives of the House of Delegates, the council directed weekly publications of the Mississippi Medical Legislative Report and operated an Emergency Care Unit at the Capitol. In addition, the council also established a Legislative Contact Committee composed of the personal physician or a physician-friend of each member of the legislature. As a part of its ongoing program to advise each physician of how his legislator votes on health issues, the council also oversaw development of a Health Voting Index for each legislator during the 1972-76 term.

MSMA 1974 Legislative Program. In addition to monitoring all health-related bills that were introduced in the 1974 Legislative Session, the association had a four-point legislative program based on prior actions of the House of Delegates as follows: (1) establish an Office of State Medical Examiner; (2) provide health insurance coverage for newborns; (3) provide for an expanded role for the registered nurse; and (4) permit MSMA to consult with the

Commissioner of Insurance in order to develop a uniform claim for physician services. Based on policy actions of the Board of Trustees, as recommended by the Council on Legislation, the association also actively supported legislation to: (1) regulate emergency medical services; (2) establish a State Department of Mental Health (with professional leadership); (3) provide a legal shelter for peer review; (4) establish a Division of Alcoholism and Alcohol Abuse under the State Board of Health; (5) permit an M.D. to examine a person for commitment in his office; and (6) create a South Mississippi Retardation Center.

All of these measures, with the exception of the bill to provide a legal shelter for peer review, were passed by both houses of the legislature and signed into law by the Governor.

In addition to its positive legislative program during 1974, the association also successfully opposed measures which provided for the following: (1) permit chiropractors to participate in the Medicaid Program; (2) require health insurance policies to reimburse chiropractors; (3) regulate ophthalmic dispensers; and (4) permit optometrists to diagnose and use medications.

Future Legislative Activities and Recommendations. The association has always adopted a position on legislation affecting a particular medical-specialty organization. It is felt that such a policy should continue, but only after all due consideration is given to such factors as the effect of the legislation on the practice of medicine in its entirety and the profession's responsibility for assuring the good health of the public. The council feels that no one individual or organization should be permitted to overly influence the Association's posture on any legislation to the extent that it will not be representative of the feelings of the vast majority of the membership.

It is almost a certainty that many, if not all, of the bills opposed by the council during this legislative session will be introduced in the succeeding session. Needless to say, your council was gravely concerned over the obvious influence by chiropractors on members of the Senate. Although the association was successful in defeating all of the measures contrary to scientific medicine, it was not without a great effort by what can be considered a small portion of the entire membership. If the health of the public is to be safeguarded in the future, it is imperative that all physicians make an exerted effort to neutralize the gains in influence which have been made by the traditional foes of scientific medicine. This can only be done by an active involvement on the local level in the affairs of the legislature, and more particularly, through continuous interaction and communication with legislators by physicians who reside in their electoral district. Your council has worked hard in developing a Health Voting Index on legislators and it can only prove to be valuable if it is utilized by physicians on the local level to communicate with their legislators about their votes on vital health issues. The council, therefore, recommends that medical staffs and component societies utilize these voting reports as a basis for meeting with their legislators not only to discuss voting records but to make the feelings of medicine known to them on health matters.

Your council feels that the medical profession must be vitally concerned with the question of who will represent them in the Legislature every four years and that no one should, in fact, be elected to office by what amounts to default. As such, the council recognizes that physicians must, as an organized body, become actively involved in the election of individuals who will represent them in the Legislature and that this involvement in elections is the most predictable method of assuring that laws will not be passed which in any way infringe upon or ameliorate good health care for the public. Your council, therefore, recommends that all due consideration be given to authorizing involvement of the Mississippi Medical Political Action Committee in statewide legislative races in 1975 and that such involvement be directed at educational activities and organization and support of "Local Candidate Support Committees" composed of physicians and their views.

Lastly, during this session of the Legislature, a bill was introduced at the request of the State Board of Health to require an annual renewal of physician licenses. This bill generated much confusion and feelings on both sides of the issue, and your council decided that it should not recommend a position on such an important matter in the absence of any mandate from the House of Delegates. In view of this, the council has invited the State Health Officer to address the appropriate Reference Committee at the 106th Annual Session to explain both the necessity for and scope of a mandatory annual license renewal so that a position can be recommended if this legislation is introduced in the 1975 Legislative Session.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the report of the Board of Trustees concerning the association's 1974 legislative program. We wish to note that the association had one of its most successful legislative programs in recent years. We can do even more, however, and we note in this regard the recommendation contained in the legislative report that our Mississippi Political Action Committee involve itself in initiating local candidate support committees during next year's legislative races. These committees would be composed of physicians, their wives and friends. We concur with this recommendation.

As noted in the legislative report during the last session of the Mississippi Legislature a bill was introduced at the request of the State Board of Health to require an annual registration pf physicians' licenses. We were very grateful to have Dr. Alton B. Cobb, State Health Officer, appear before our reference committee to discuss this proposed bill. Dr. Cobb has told us that the purpose of the bill is to obtain an annual listing of all physicians practicing in Mississippi. He has assured us that the bill would not contain any criteria for annual registration. We believe that this legislation as described by Dr. Cobb should be supported by the association. We further believe that the annual license registration fee should not exceed $10.00.

Your reference committee recommends adoption of the report.

Dr. G. Swink Hicks, Natchez, then moved, seconded by Dr. Stanley Hill, Corinth, that the report of the reference committee be amended as follows:

> "that the subject of annual registration be referred to the Board of Trustees for study during the next twelve months and that the Board report back to the House in this regard at the 107th annual session."

The speaker called for a vote on the motion and it prevailed.

The report of the committee was adopted as amended.

SUPPLEMENTAL REPORT B OF THE BOARD OF TRUSTEES

Background. After careful deliberation, your Board of Trustees and Council on Budget and Finance are recommending a dues increase. There are two major reasons for this recommendation: (1) to put the association on a sound financial basis, and (2) to eliminate the association's financial dependence on government programs. The following facts should be noted in this regard.

At Dec. 31, 1973, the association had received $97,749.66 in prepaid income (1974 dues, etc.). Without this prepaid income, the association would have a deficit working capital of $22,595.39 at Dec. 31, 1973. Working capital is the excess of current assets over current liabilities. Current assets are cash plus items expected to be converted into cash or used in operations within 12 months. Current liabilities are liabilities due and payable within 12 months. In short, working capital would be your cash position if all receivables, etc. were converted to cash and all liabilities paid.

This means that the association had to use $22,595.39 of 1974 income to pay 1973 expenses. Detailed below are thc association's sources of working capital and the way it was used for the past five years:

Working Capital Provided From Operations: Increase (Decrease)		
Net Operating Loss: 1969 ($5,058.96); 1970 ($35,357.67); 1971 $5,833.10; 1972 $7,226.32; 1973 $17,432.59		$ (9,924.62)
Add Non Current Items		
Depreciation	$ 39,755.22	
Expenses incurred prior to 12/31/68 and deferred to current period	1,534.36	41,289.58
Total working capital provided from operations		$ 31,364.96
Working Capital Provided From Other Sources		
Long Term Borrowings	$ 89,000.00	$
Less Amount Payable within 12 months	4,450.00	84,550.00
Total Working Capital Provided		$115,914.96
Uses of Working Capital		
Additions to Fixed Assets—Building and Equipment	156,653.00	
Reduction of Long Term Debt	30,548.41	
Expenses incurred prior to 12/31/73 and deferred to future operations	17,268.93	
Lease deposits and advances to Mississippi Foundation for Medical Care	2,710.43	207,180.77
Increase (Decrease) in Working Capital		$(91,265.81)
Working Capital 12/31/68 With Prepaid Income Eliminated		68,670.42
Working Capital (Deficit) 12/31/73 With Prepaid Income Eliminated		$(22,595.39)

It can readily be seen that a major part of the requirements for working capital was for additions to

fixed assets, of which a substantial amount was to accommodate the expanding government programs. However, during the same period these programs were charged with facility usage (rent) of $41,145.52 and executive salaries of $57,582.61 or a total of $98,728.13. This does not include payroll taxes, fringes, other staff salaries, and sundry expenses that are charged to these programs. *It is estimated that in 1974 these programs will absorb a minimum of $30,000 which would otherwise have to be paid from association income.*

Had the association not expanded its facilities to accommodate these programs, it would be in substantially the same financial position due to having to fund the fixed cost absorbed by these programs and increased operating cost as the result of runaway inflation.

Our auditors have advised us for the last few years that we are in a precarious financial position, and are highly dependent on government programs for current funding. They recommend that we strongly consider a dues increase. Current MSMA dues are $100 per year.

A dues increase will allow the association to discontinue the use of coming years' dues to pay the years' expenses, to continue and expand the service rendered the membership, and to build adequate reserves to fund the fixed cost absorbed by the government programs should they be lost.

Finally, it should be noted that your Board of Trustees and Council on Budget and Finance have instructed our staff to investigate certain business services offered by other medical associations to their members which serve as sources of income to these associations in lieu of increased membership dues. We are hopeful that such services can be implemented through our association in this manner. We must seek and plan a dues increase now, however, based on the Association's present financial condition.

Recommendation. Your Board of Trustees and Council on Budget and Finance recommend a dues increase of $25 effective with 1975 dues with authority for the Board to raise dues up to an additional $25 thereafter based on appraisal of the association's financial condition.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Supplemental Report B of the Board of Trustees which notes the need for a dues increase for membership in the association. Your reference committee believes that the information furnished in this report more than substantiates the need for this dues increase. It is the recommendation of the Board and the Council on Budget and Finance that there be a dues increase of $25.00 effective with 1975 dues with authority for the Board to raise dues up to an additional $25.00 thereafter based on appraisal of the association's financial condition. Your reference committee recommends a dues increase of $25.00 effective with 1975 dues and also recommends that any further dues increases continue to be approved by the House of Delegates.

The report of the reference committee was adopted.

SUPPLEMENTAL REPORT C OF THE BOARD OF TRUSTEES

Scheduling of MSMA Annual Sessions. The Constitution of the association provides for the annual session, and under the By-Laws, it must be conducted prior to the annual convention of AMA. Section 2, Article V, of the Constitution states that "the time and place for holding the annual session shall be fixed by the House of Delegates, but in emergencies, the Board of Trustees shall have the power to fix or change either the time or the place or both. . . ." Because of scheduling difficulties on a year-to-year basis, the House of Delegates approved a four-year advance schedule beginning in 1967.

A resolution was passed by the House of Delegates in 1970 directing that the annual sessions be scheduled to avoid conflict with Mother's Day and with municipal elections. The former occurs on the second Sunday in May; primaries for the latter occur on the second Tuesday in May every four years.

Dates and Sites for the Annual Sessions. At the 99th Annual Session in 1967, the House agreed that the annual sessions thereafter would be conducted on the Gulf Coast "until such time as more adequate and suitable convention facilities are made available in Jackson."

To maintain a four-year advance schedule, the Board of Trustees recommended the following convention schedule which was adopted at the 1973 Annual Session:

Annual Session	*Dates*
106th	May 6-9, 1974
107th	May 5-8, 1975
108th	May 3-6, 1976
109th	May 2-5, 1977

Recommendation. Your Board of Trustees has

been informed of plans to construct a new hotel in Jackson which would accommodate the association's annual meeting. Another new hotel which would accommodate us is being constructed on the Gulf Coast. The Board wishes to bring this to the attention of the House of Delegates and recommends that the House consider future scheduling of annual sessions in light of the additional facilities available to us. Following the above format, the 110th Annual Session would be held May 1-4, 1978, at a place to be designated by the House of Delegates.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the report of the Board of Trustees concerning the scheduling of annual meetings of the association. The following schedule of annual sessions has already been adopted by the House of Delegates:

Annual Session	*Dates*
107th	May 5-8, 1975
108th	May 3-6, 1976
109th	May 2-5, 1977

The 110th annual session of the association following policies of the House of Delegates would be held May 1-4, 1978.

During discussion of the time and place for the association's annual sessions, it was brought to your reference committee's attention that Central Medical Society has invited the association to meet in Jackson in 1976. It was also brought to our attention that a new hotel would be constructed in Jackson by that time which could accommodate the association's meeting. It is the recommendation of your reference committee that we accept the invitation of the Central Medical Society to meet in Jackson in 1976 and that the association thereafter meet on the Gulf Coast in odd numbered years and in Jackson in even numbered years.

The report of the reference committee was adopted.

REPORT OF THE SECRETARY-TREASURER

Dr. James P. Spell: Duties and Responsibilities. As an elected general officer of the association, your Secretary-Treasurer is charged with such duties as ordinarily devolve upon the secretary of a corporation by law, custom, and usage. Additionally, he is the constitutional designee to serve as chairman of the Council on Scientific Assembly and member *ex officio* of all councils and committees.

Membership. Total membership as of Dec. 31, 1973, was as follows:

1,357 paid Active members
55 Emeritus members
33 members exempt from dues other than Emeritus

This is a total of 1,445 MSMA for 1973. I think that it is interesting to note that as of Dec. 31, 1972, we had 1,302 paid Active members. There has been a significant increase in membership which we hope to see continue. As of April 15, 1974, our current year's membership was:

1,344 paid Active members
47 Emeritus members
40 members exempt from dues other than Emeritus

This is a total of 1,431 for 1974. Additional payments of dues have been made since preparation of these data, and there are 57 unpaid members who were in good standing in 1973. Final date for payment of MSMA 1974 dues is April 1.

Fiscal Reporting. In accordance with usual practice, your Secretary-Treasurer submits a condensed statement of your association's financial condition. The Council on Budget and Finance prepared the budget for 1974 which was approved by the Board of Trustees, and a copy is attached to this report.

Constitutional Duties. Your Secretary-Treasurer, as an *ex officio* member of councils and committees, meets with various official bodies of the association and sits with the Board of Trustees as a general officer. Activities related to service as chairman of the Council on Scientific Assembly are reported separately.

MEMBERSHIP SUMMARY—AS OF APRIL 15, 1974

Society	*Paid MSMA 1974*	*Total Paid MSMA 1973*	*Paid AMA 1974*	*Total Paid AMA 1973*
Homochitto Valley	46	52	38	46
Amite-Wilkinson	7	7	7	7
Central	390	396	320	314
Claiborne Co.	2	2	2	2
C'Dale & Six	35	36	33	30
Coast Counties	101	104	81	90
Delta	106	107	94	98
Desoto Co.	6	5	5	5
East Miss.	95	97	83	91
North Miss.	47	47	45	40
North Central	38	37	35	35
Northeast	122	115	110	107
Pearl River	13	13	10	12
Prairie	46	46	41	40
Singing River	46	44	29	29
South Miss.	147	155	134	139
South Central	52	50	44	46
West	45	44	41	42
	1,344	1,357	1,152	1,173

MISSISSIPPI STATE MEDICAL ASSOCIATION
CONDENSED STATEMENT OF FINANCIAL CONDITION
DECEMBER 31, 1973

ASSETS

Current Assets		
General Fund		
Cash on Deposit	$ 97,323.28	
Accounts Receivable—Journal	3,932.47	
Accounts Receivable—CHAMPUS	21,112.50	
Other Current Receivables	17,650.09	
Prepaid Expenses	192.14	
Total Current Assets		$140,210.48
Fixed Assets		
Building, Office Furniture and Equipment, Less Depreciation	$185,951.55	
Land (at cost)	14,242.38	
Total Fixed Assets		$200,193.93
Deferred Expenses		
Deferred CHAMPUS Expenses	$ 12,815.69	
Deferred Pension Plan Expense	4,453.24	
Total Deferred Expenses		$ 17,268.93
Other Assets		
Refundable Deposits	$ 202.98	
Due from Mississippi Foundation for Medical Care	2,532.45	$ 2,735.43
Total Assets		$360,408.77

LIABILITIES AND NET WORTH

Current Liabilities		
Bank Overdraft	$ 6,912.63	
Accrued Expenses	22,939.31	
Accounts Payable:		
Local Society Dues	3,762.00	
Auxiliary Dues	4,665.00	
Workshop Registration	680.00	
Accounts Payable—AMA Dues and ERF	12,039.00	
Accounts Payable—Dues AMPAC and MPAC	6,940.00	
Accounts Payable—U. S. Government—EMCRO	96.71	
CHAMPUS	1,018.30	
Mortgage Payable Current Portion	4,450.00	
Accrued Taxes	1,553.26	
Total Current Liabilities		$ 65,056.21
Long Term Liabilities		
Mortgage Payable—Deposit Guaranty National Bank		$ 62,300.00
Deferred Income		$ 97,749.66
Net Worth		
Unappropriated Net Worth, December 31, 1972	$117,870.31	
Net Income for Year Ended December 31, 1973	17,432.59	
Net Worth, December 31, 1973		$135,302.90
Total Liabilities and Net Worth		$360,408.77

MISSISSIPPI STATE MEDICAL ASSOCIATION
1974 BUDGET

Projected Income		
Dues Sources		
MSMA		$ 140,000.00
AMA		130,000.00
AMA Commissions		1,300.00
Directory and Supplement		6,000.00
Journal		
Advertising	$ 27,000.00	
Other (Rebate, Paid Subs.)	1,700.00	
Reprints	1,000.00	$ 29,700.00
106th Annual Session		
Exhibit Sales	$ 9,000.00	
Scientific Grants	800.00	
Social Occasion	750.00	$ 10,550.00
Other Income		
Interest Earned	$ 3,000.00	
Sundry Sales	1,000.00	
Data Processing	1,000.00	
CHAMPUS Administration	120,000.00	
EMCRO Grant	284,000.00	$ 409,000.00
Total		$ 726,550.00
Less AMA Transmittals		–130,000.00
Less EMCRO Grant		–284,000.00
Less CHAMPUS Administration		–120,000.00
Net Projected Income		$ 192,550.00
Projected Expenses		
106th Annual Session		$ 8,830.00
Board of Trustees		3,800.00
Councils and Committees		2,000.00
Committees—CHAMPUS		500.00
Building Maintenance		3,300.00
Contract Labor		300.00
Dues and Subscriptions		650.00
Equipment Rentals		3,500.00
Office Equipment Maintenance		900.00
Office Equipment Maintenance—CHAMPUS		400.00
Office Equipment Maintenance—EMCRO		150.00
Grounds Maintenance		800.00
Group Insurance		3,646.00
Group Insurance—CHAMPUS		3,333.00
Group Insurance—EMCRO		3,647.00
Other Insurance		1,000.00
Interest		4,025.00
Other Office Expenses		350.00
Postage		9,000.00
Postage—CHAMPUS		9,000.00
Postage—EMCRO		2,650.00
Professional Services		2,000.00
Professional Services—CHAMPUS		1,000.00
Consultant Services—EMCRO		33,770.00
Pension Plan		1,400.00
Data Processing Services		9,600.00
Data Processing Services—CHAMPUS		8,300.00
Data Processing Services—EMCRO		79,200.00
Salaries		92,877.00
Salaries—CHAMPUS		68,136.00
Salaries—EMCRO		114,362.00
Printing and Supplies		13,250.00
Printing and Supplies—CHAMPUS		6,600.00
Printing and Supplies—EMCRO		12,000.00
Property Taxes		6,700.00
Payroll Taxes		5,238.00
Payroll Taxes—CHAMPUS		4,581.00
Payroll Taxes—EMCRO		7,190.00
Telephone and Telegraph		8,000.00
Telephone and Telegraph—CHAMPUS		4,000.00
Telephone and Telegraph—EMCRO		5,000.00
Travel		8,000.00
Travel—CHAMPUS		1,000.00

Travel—EMCRO	10,000.00
Utilities	6,000.00
Journal Production	27,200.00
Journal Other	1,900.00
Journal Reprints	1,100.00
EMCU	2,600.00
Total	$ 602,785.00
Less OCHAMPUS Expenses	−106,850.00
	$ 495,935.00
Less EMCRO Grant	−267,969.00
Net Projected Expenses (MSMA)	$ 227,966.00

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered the report of our secretary-treasurer, Dr. James P. Spell, Jr. We note with appreciation the increase in membership in our association, and we commend the concerned officers of the association in this regard. Your reference committee recommends adoption of the report.

The report of the reference committee was adopted.

REPORT OF THE EXECUTIVE SECRETARY

Mr. Charles L. Mathews, Executive Secretary: Your office of Executive Secretary, under the By-Laws, reports to the Board of Trustees. The present report omits this detailed reporting and is limited to an overview of your administrative staff and ongoing association activities.

Staff. There are at present 36 employees on your staff, an increase of 14 staff members since I reported to you last year. Fourteen of your staff members have duties with the Experimental Medical Care Review Organization (EMCRO). Thirteen have duties with the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and nine (an increase of one since last year to fill a vacant authorized position) have duties with association programs such as membership, the JOURNAL, and internal management. In the latter it is significant to note that three employees have 50 per cent time responsibilities with CHAMPUS. Based on approval of the Board, two key staff positions that were reported vacant last year have been filled. Mr. William F. Roberts, an attorney, has joined your staff with primary duties in legislation and with the Council on Medical Service. Mr. Tom F. Buntyn, a mathematician and systems analyst/programmer, has joined your staff with primary duties in systems design and programming.

Association Programs. Based on approval of the Board of Trustees and the House of Delegates, we have acted to expand those activities of the association particularly dealing with communication and service to the membership. I would like to just briefly touch on some of these. We now have a toll-free line available to any member who wishes to call for assistance or information and we have filled many requests in this regard. Summaries of all meetings of the Board of the association and the Mississippi Foundation for Medical Care are now published in the JOURNAL MSMA. We have recently contacted each member of the association to seek their views on the design of the uniform insurance claim form for physician services that is now required by statute in Mississippi. During the past year the Medicare "Prevailing Fee Guidelines for Mississippi" were obtained and furnished to each member on request at a cost considerably below that available to an individual.

Under the direction of the Board of Trustees we are now investigating new areas of service to the membership. You will be hearing more about this in the months to come. Let me say now, however, that the effort will be to offer a needed service in a better way and at less cost.

Summary. In summary, your association continues to grow. During this past year emphasis has been placed on better communication and service to the membership. Much work remains to be done in this and other areas of concern to your profession. Speaking on behalf of the staff we appreciate the confidence you have reposed in us to get the job done.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received the report of our executive secretary. We wish to join the House of Delegates in recognizing and commending our staff.

The report of the reference committee was adopted.

REPORT OF THE AD HOC COMMITTEE TO STUDY REALIGNMENT OF ASSOCIATION DISTRICTS

1. *Background.* At the 105th Annual Session of the association, May 1973, the House of Delegates considered the following recommendations of the president and resolutions from the West Mississippi and Central Medical societies dealing with composition and terms of office of the MSMA Board of Trustees and realignment of the association's districts.

President's Address—Recommendation No. 4

Recommend ". . . that an ad hoc committee of the

House of Delegates be formed to study realignment of the nine association districts to more equitably divide the districts as to number of physician members—this committee to report back with concrete suggestions to the 1974 House of Delegates. . . ."

Resolution No. 2 (West Miss. Medical Society)

Resolved ". . . That Section VIII, Article 8 of the MSMA Constitution be amended to provide that all trustee districts shall include substantially equal numbers of MSMA members. . . ."

Resolution No. 11 (Central Medical Society)

Resolved (to amend) ". . . the Constitution of the Mississippi State Medical Association to increase the membership of the Board of Trustees from 9 to 11. One of the newly created trustees would be elected from the membership of the West Mississippi Medical Society of (Trustee) District 5 and the other newly created trustee would be elected from the Central Medical Society of (Trustee) District 5. The existing trustee would be elected at large from District 5. The three year terms of office for the trustees from District 5 are to be so arranged that one will be elected annually. . . ."

Actions by the House of Delegates. The House of Delegates took the following action on the president's Recommendation No. 4 and Resolution No. 2:

> ". . . that an Ad Hoc committee of the House of Delegates be formed to study realignment of the nine association districts to more equitably divide the districts as to number of physician members. . . . Further . . . that said Ad Hoc committee return with a definitive plan for implementing the redistricting of the districts at the 106th Annual Session of the association. . . ."

The House of Delegates took the following action on Resolution No. 11:

> ". . . that Resolution No. 11 be not adopted and be referred to the Ad Hoc study committee noted previously. . . ."

President's Address—Recommendation No. 1

> ". . . That the tenure of office of future members of the Board of Trustees be limited to two three-year terms rather than the (present) three. The tenure of the present members of the Board would not be affected. . . ."

Action by the House of Delegates. The House of Delegates took the following action on the president's Recommendation No. 1:

> ". . . this recommendation be not adopted and referred to (an) Ad Hoc committee (to study realignment of the association's districts). . . ."

President's Address—Recommendation No. 2

> ". . . That the president and speaker of the House be voting members of the Board of Trustees—this is in line with the AMA, American Academy of Family Physicians, and other national medical organizations. . . ."

Action by the House of Delegates. The House of Delegates took the following action on the president's Recommendation No. 2:

> ". . . That the reference committee report (recommending that the president, speaker of the House, and secretary-treasurer be voting members of the Board of Trustees) be not adopted and be referred to (an) Ad Hoc committee (to study realignment of the association's Districts). . . ."

President's Address—Recommendation No. 3

> ". . . That the immediate-past president sit with the Board of Trustees—this to become effective in 1974. . . ."

Action by the House of Delegates. The House of Delegates took the following action on the president's Recommendation No. 3:

> ". . . adoption of Recommendation No. 3 as contained in the president's address, beginning in 1973. . . .

Subsequent to the above actions and in accordance with the By-Laws of the association, the president of the association acted to appoint an ad hoc committee to implement the wishes of the House of Delegates.

2. *Study Format and Recommendations of the Ad Hoc Committee on Realignment of the Association's Districts. The Ad Hoc Committee on Realignment of the Association Districts* had conducted several meetings and conferred with officers of the association and the membership in connection with the committee's assigned responsibilities. The recommendations and resolutions before the committee touch on the following subject areas and portions of the Constitution and By-Laws of the Mississippi State Medical Association:

(a) *Realignment of the Association Districts.* The present nine members of the Board of Trustees, Council on Legislation, Council on Medical Service, and Judicial Council are elected by the House of Delegates from the association's nine districts (MSMA Constitution, Article IX and By-Laws, Chapter VII—Section 1, Chapter IX—Sections 2, 4, and 6). Additionally, the Committee on Nominations of the House of Delegates consist of nine members of the House of Delegates, one from each association district (MSMA By-Laws, Chapter VI—Section 2) and all component societies of the association are organized within association districts (MSMA By-Laws, Chapter VIII—Section 8).

(b) *Tenure of Members of the Board of Trustees.* Members of the Board presently serve terms of three years each limited to three consecutive terms (MSMA Constitution, Article IX and By-Laws, Chapter VIII—Section 1). Additionally, members of the Council on Medical Service, Council on Scientific Assembly, Judicial Council, Council on Constitution and By-Laws, Council on Legislation, Council on Budget and Finance, Editorial Council, and Council on Medical Education are prohibited from serving more than three consecutive terms (MSMA By-Laws, Chapter IX—Section 1).

(c) *Composition of the Board of Trustees.* The MSMA Board of Trustees is presently composed of nine elected members, one from each association district (MSMA Constitution, Article IX and By-Laws, Chapter VIII—Section 1). Additionally, by tradition and invitation, the president, president-elect, immediate-past president (effective with House of Delegates' action in 1973), secretary-treasurer, speaker, vice speaker, and two AMA Delegates sit with the Board.

3. *Recommendations of the Committee.* After consideration of the above, your committee makes the following recommendations:

(a) The realignment of MSMA Association districts was a matter of much discussion by your committee. Several plans were presented. Your committee recommends a realignment of association districts that provides for a range of 142 to 183 MSMA members per district; Hinds county with a present MSMA membership of 366 will become two districts. The realignment plan recommended by your committee will cross some of the present component society lines but there is absolutely no way to avoid this. The societies will be called on to readjust their boundaries within the new districts. The committee recommends that the new districts be implemented upon the expiration of present terms of members of the Board of Trustees and appropriate councils beginning in 1975.

(b) It is the further recommendation of your committee, after much deliberation, that the president and immediate-past president of the association be made voting members of the Board of Trustees. It is the opinion of your committee that the president of the association, as the official spokesman for the association, should certainly have a vote on the Board of Trustees. It is also the opinion of your committee that the immediate-past president, having just completed a year "on the line service" in national, state, and local medical organizations, should be called on to exercise a vote as a member of the Board of Trustees.

(c) In addressing the tenure of office of Board members, it is the opinion of your committee that the terms of office of members of the Board of Trustees should be limited to two consecutive terms of three years each. We base this recommendation on the belief that all members of the association should have a more timely encouragement to serve in positions of leadership within our Mississippi State Medical Association. We further recommend that tenures of office on councils of the association be limited to a two consecutive three-year term requirement and that no member be eligible for reelection to the Board or to the same council who has served two consecutive terms until that individual has been off of the Board or council for at least six years.

4. *Implementation Plan.* The recommendations of your committee will require extensive amendments to our present Constitution and By-Laws of the Mississippi State Medical Association.

Based on approval of your committee's recommendations, it is proposed that the House of Delegates select a Committee on Nominations (By-Laws, Chapter VI, Section 2) and elect Board and council members based on the new districts beginning in 1975 and annually thereafter for those terms of office presently scheduled to expire by districts as follows:

	Board of Trustee Districts	*Council on Legislation Districts*	*Judicial Council Districts*	*Council on Med. Service Districts*
1975	789	789	456	123
1976	123	456	789	789
1977	456	123	123	456

Under the above proposal, all Board and appropriate council members would be elected from the new association districts by the end of the 1977 Annual Session. It is proposed that those present counties whose component society boundaries will overlap two association districts under the new plan be required to form or join component societies within their respective new association districts in a timely manner after the 1975 Annual Session and prior to the 1976 Annual Session.

5. *Expression From Committee.* Your committee appreciates the assistance and guidance it received from the president and members of the Board of Trustees and association in its study and deliberations. The subject matter handled by the committee is very involved and we would certainly not wish to claim or imply ourselves as a final authority in this regard. Serving on your committee are: C. D. Taylow, M.D., Pass Christian, Chairman; Whitman B. Johnson, Jr., M.D., Clarksdale; Lee H. Rogers, M.D., Tupelo; Frank H. Tucker, Jr., M.D., Meridian; John B. Howell, Jr., M.D.,* Canton; J. Manning Hudson, M.D., Jackson; William L. Weems, M.D., Jackson; John M. McRae, Jr., M.D., Laurel; Ralph L. Brock, M.D., McComb.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

Your reference committee appreciates the extensive work this report represents. This matter created extensive discussion before the committee. The recommendations of the *ad hoc* committee are as follows:

(a) "Your committee recommends a realignment of association districts that provides for a range of 142 to 183 MSMA members per district; Hinds County with a present MSMA membership of 366 will become two districts. The realignment plan recommended by your committee will cross some of the present component society lines but there is absolutely no way to avoid this. The societies will be called on to readjust their boundaries within the new districts. The committee recommends that the new districts be implemented upon the expiration of present terms of members of the Board of Trustees and appropriate councils beginning in 1975.

(b) "It is the further recommendation of your committee, after much deliberation, that the president and immediate-past president of the association be made voting members of the Board of Trustees. It is the opinion of your committee that the president of the association, as the official spokesman for the association, should certainly have a vote on the Board of Trustees. It is also the opinion of your committee that the immediate-past president, having just completed a year "on the line service" in national, state, and local medical organizations, should be called on to exercise a vote as a member of the Board of Trustees.

(c) "In addressing the tenure of office of Board members, it is the opinion of your committee that the terms of office of members of the Board of Trustees should be limited to two consecutive terms of three years each. We base this recommendation on the belief that all members of the association should have a more timely encouragement to serve in positions of leadership within our Mississippi State Medical Association. We further recommend that tenures of office on councils of the association be limited to a two consecutive three-year term requirement and that no member be eligible for reelection to the Board or to the same council who has served two consecutive terms until that individual has been off of the Board or council for at least six years."

Recommendation (a) of the committee created the most discussion before your reference committee, particularly with respect to the recommendation's effect on present component society boundaries. A new realignment plan was proposed before your committee in lieu of the plan proposed in the report. This new realignment plan is attached to your reference committee's report. The plan *would not* disrupt any of the present component societies of the association and would give better representation to all societies. Your committee recommends adoption of the new plan in lieu of that plan proposed in the *ad hoc* committee's report. It should be noted that this recommendation along with other recommendations of the *ad hoc* committee will have to lie on the table for one year. It should be noted also that the plan, if adopted, would give Hinds County two trustees and that *all trustees would continue to be elected by the House of Delegates as presently provided.*

In considering Recommendation (b) of the *ad hoc* committee, your reference committee considered the fact that the plan proposed above would create an eight-member Board of Trustees. Your committee is in accord with the recommendation of the *ad hoc*

* Deceased April 3, 1974.

committee that the president and immediate-past president of the association should be made voting members of the Board of Trustees. It is also the feeling of your committee that the secretary-treasurer of the association should be a voting member of the Board of Trustees and we recommend amendment of Recommendation (b) to include the secretary-treasurer. We therefore recommend adoption of Recommendation (b) of the *ad hoc* committee as amended to make the president, the immediate-past president, and the secretary-treasurer voting members of the Board of Trustees.

In considering Recommendation (c) of the *ad hoc* committee, it was the unanimous opinion of those appearing before your reference committee that this recommendation should be adopted as proposed. We therefore recommend adoption of this recommendation.

Your reference committee recommends adoption of the report.

Dr. Robert Caldwell, Tupelo, offered a substitute motion, seconded by Dr. A. T. Tatum, Petal, as follows:

> "The report of the Reference Committee on Constitution and by-laws be amended to state that an additional trustee be elected from District 5 in lieu of the realignment of the present trustee districts as proposed in the Committee's report; and further that the Committee's recommendation that the Secretary-Treasurer of the Association become a voting member of the Board be deleted."

Dr. Charles R. Jenkins, Laurel, requested a division of the question on Dr. Caldwell's motion as follows:

> (1) "That an additional trustee be elected from District 5 in lieu of the realignment of the present trustee districts as proposed in the Committee's report, and (2) "That the Committee's recommendation that the Secretary-Treasurer of the Association become a voting member of the Board be deleted."

The speaker then ruled that the motion of Dr. Caldwell be divided into two parts, and that the question properly before the House concerned the motion that an additional trustee be elected from District 5 in lieu of realignment of the present districts.

A motion was then made by Dr. Stanley A. Hill, Corinth, seconded by Dr. Boyce White, Laurel, that consideration of the question pending before the House be tabled subject to the completion of action on the election of officers. The motion carried and following the vote on run-offs for two officers' posts, the order of the day was resumed, whereupon the speaker called for a vote on motion No. 1 as proposed by Dr. Jenkins:

> "that the report of the Committee on Constitution and By-laws be amended to state that an additional trustee be elected from District 5 in lieu of the realignment of the present trustee districts as recommended by the Committee."

whereupon the motion prevailed.

The speaker called for a vote on motion No. 2:

> "that the Committee's recommendation that the Secretary-Treasurer of the Association become a voting member of the Board be deleted."

whereupon the motion prevailed.

Dr. Tom H. Mitchell, Vicksburg, then moved* that the report of the Committee on Constitution and By-Laws be adopted as amended and the motion carried.

AUXILIARY OFFICERS

The speaker presented Mesdames W. H. Preston of Booneville, 1973-74 president of the Woman's Auxiliary to the Mississippi State Medical Association, and J. Edward Hill of Hollandale, new president-elect of the woman's group, who addressed the House of Delegates. Mrs. Dan Reikes of Hattiesburg, 1974-75 president, was unable to be present, but she sent a letter which was read to the House by Mrs. Hill.

1974 MSMA-ROBINS AWARD

President Derrick presented the 1974 Mississippi State Medical Association-Robins Award to Dr. Virginia S. Tolbert of Ruleville for outstanding community service by a physician. Dr. Tolbert, a family practitioner, was cited for her work in city government, sanitation and environmental control. Mr. Willard Duval from the A. H. Robins Company of Richmond, Va., assisted Dr. Derrick in the presentation of the award, an engraved plaque.

SPECIAL MEETING OF THE MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The motion was made by Dr. Sidney Graves of Natchez, seconded by Dr. Whitman Johnson of

* Effective 10/73.

* This action represents an amendment to the MSMA Constitution which must lie on the table for one year pending final action at the 107th annual session.

Clarksdale, and passed, to recess the House of Delegates for the third annual meeting of the Mississippi Foundation for Medical Care.

Dr. J. T. Davis of Corinth, MFMC president, presented the annual report. Dr. Gerald P. Gable of Hattiesburg, chairman of the Committee on Fees, gave the committee's report. Dr. Tom H. Mitchell of Vicksburg, chairman of the Subcommittee on PSRO Planning, presented the PSRO plan for Mississippi to the MFMC members.

On motion by Dr. J. Dan Mitchell, Jackson, seconded by Dr. G. Swink Hicks, Natchez, the meeting of the foundation was adjourned.

RESOLUTION NO. 1, IN MEMORIAM

Dr. James P. Spell:

WHEREAS, There are absent from among our numbers 29 members who have been called by Divine Providence since the 105th Annual Session; and

WHEREAS, Although we are grieved by the passing of these beloved colleagues and friends, we are inspired by their lives of service and professional attainment; and

WHEREAS, This expression of our grief, deep affection, and respect should be recorded permanently among official records of the Mississippi State Medical Association, now therefore, be it

Resolved, That this House of Delegates does mourn the passing of the following esteemed colleagues:

Dewitt T. Allred, Collins, March 12, 1974
Calvin C. Applewhite, Jackson, November 19, 1973
Allie M. Aycock, Rose Hill, December 31, 1973
Homer D. Barber, Biloxi, December 6, 1973
James G. Blaine, Hazlehurst, January 21, 1974
Riley W. Burnett, Biloxi, July 14, 1973
Isaac P. Carr, Clarksdale, August 6, 1973
Kenneth M. Clements, Gulfport, April 19, 1973
Floyd M. Davis, Grenada, May 29, 1973
Thomas S. Eddleman, Jackson, January 9, 1974
Boyd C. Edwards, Jackson, February 4, 1974
Elias K. Guinn, Okolona, May 16, 1973
Lee L. Hasseltine, Corinth, August 31, 1973
Richard G. Hendrick, Okolona, May 19, 1973
William C. Holland, Jr., Jackson, May 22, 1973
John B. Howell, Jr., Canton, April 3, 1974
A. D. Jones, Holly Springs, October 8, 1973
William P. Kyle, Biloxi, December 24, 1973
Edwin D. McMorries, Jr., Long Beach, February 14, 1973
E. A. McVey, Sr., Lambert, April 26, 1973
W. E. Noblin, Jr., Jackson, December 27, 1973
L. M. Owen, Vicksburg, March 3, 1974
Mal S. Riddell, Jr., Winona, November 29, 1973
C. G. Rotenberry, Mendenhall, January 11, 1974
Walter W. Scott, Jackson, June 15, 1973
James Grant Thompson, Jackson, February 23, 1974
B. C. Tubb, Smithville, October 13, 1973
Thomas E. Wilson, Jr., Jackson, January 20, 1974
Namo Yeates, Lula, April 15, 1973

ACTION OF THE HOUSE OF DELEGATES

Without objection, Resolution No. 1 was acted upon without referral and adopted by the House of Delegates with all present standing in silent tribute.

RESOLUTION NO. 2, REPEAL OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Dr. Stanley A. Hill:

WHEREAS, Thirty-nine U. S. Representatives through petition and strong action from California, Georgia, Illinois, Kentucky, Louisiana, Michigan, and New York lent support of repeal of PSRO at the AMA clinical meeting, 1973; and

WHEREAS, This society can render valuable service to the patient by enlisting support of the Mississippi Congressional Delegation and gaining additional support of the Mississippi State Medical Association Council on Legislation; and

WHEREAS, We must work to inform the public and legislators as to the potential and deleterious effects of the PSRO law on the quality, confidentiality, and cost of medical care; therefore be it

Resolved, That the Northeast Mississippi Medical Society strongly supports repeal and that this resolution be introduced in the House of Delegates for action at the 106th Annual Session of the Mississippi State Medical Association in May.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution and two others dealing with repeal of the new Professional Standards Review Organization Program. Without doubt this is the most controversial issue before the medical profession today. Your committee heard extensive discussion in this regard.

As noted in the address of our president on Monday and the report of our Board of Trustees in the *Handbook of the House of Delegates,* our association has devoted extensive effort and interest in de-

velopment of effective peer review mechanisms. These efforts precede PSRO and it is obvious that many physicians are concerned now as to whether PSRO will be supportive or destructive of our past and future peer review efforts. Many physicians are also concerned that PSRO will be detrimental to the time-honored physician/patient relationship.

The PSRO Law does not require physician participation. It seeks this participation but it does not require it. PSRO repeal as urged by Resolution No. 2 would not end the fact of review of cost and quality of health services under Medicare and Medicaid. PSRO repeal would end a statutory requirement that our profession's participation and guidance be sought in this review.

Your reference committee recommends that Resolution No. 2 be not adopted and that it be the policy of this House of Delegates with respect to PSRO that we will seek to amend any part of the Professional Standards Review Organization Program that now or in the future has a detrimental effect on the physician/patient relationship and/or is not supportive of peer review as defined by the House of Delegates.

The report of the reference committee was adopted.

RESOLUTION NO. 3, LEGAL STANDARDS FOR HEALTH MAINTENANCE ORGANIZATIONS

Dr. Tom H. Mitchell:

WHEREAS, It is recognized that the practice of medicine as developed in these United States of America has afforded the citizens of this county medical care of the highest quality; and

WHEREAS, It is recognized that the medical profession is constantly searching for means to improve both the quality of care rendered and the delivery of health care to the population; and

WHEREAS, It is recognized that changes in our society as a whole may make it desirable that alternative means, other than the fee for service system, be developed to provide the needed health care and the access to health care; and

WHEREAS, It is recognized that the development of prepayment plans, popularly referred to as Health Maintenance Organizations, is a system favored by many, as it provides a system in which the physician may maintain control of the quality of care rendered and provides a less costly means of delivering the needed care; and

WHEREAS, It is recognized that in order to protect the public, to maintain standards assuring the delivery of quality care on a continuing basis, and to establish a legal foundation for developing such prepayment plan, certain legislation is needed within the state of Mississippi, as there is no such at the present; therefore be it

Resolved, That the West Mississippi Medical Society does by unanimous vote this 22nd day of January, 1974, request that the Mississippi State Medical Association support the development of legislation in the 1975 session of the Mississippi State Legislature to establish a legal foundation and standards for Health Maintenance Organizations; and be it further

Resolved, That the Health Maintenance Organization Act as developed by the S & M Health Plan, Inc., Vicksburg, Mississippi, and presented to the 1974 session of the state Legislature be used as a guide.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 3, introduced by Dr. Tom Mitchell, Delegate from West Mississippi Medical Society. The resolution states:

"*Resolved,* That the West Mississippi Medical Society does by unanimous vote this 22nd day of January, 1974, request that the Mississippi State Medical Association support the development of legislation in the 1975 session of the Mississippi State Legislature to establish a legal foundation and standards for Health Maintenance Organizations, and be it further

"*Resolved,* That the Health Maintenance Organization Act as developed by the S & M Health Plan, Inc., Vicksburg, and presented to the 1974 session of the state Legislature be used as a guide."

Your reference committee believes that the enactment of legal standards for HMO's would help to assure the solvency and quality of such organizations. To that end, your committee feels that regulatory sanction of existing or proposed HMO's would be in the best interest of the public, and therefore recommends the adoption of Resolution No. 3.

The report of the reference committee was adopted.

RESOLUTION NO. 4, ESTABLISHMENT OF MSMA SECTION ON ANESTHESIOLOGY

Dr. Joel Alvis:

WHEREAS, The specialty of anesthesiology is a well accepted medical specialty in the state of Mississippi and in the United States, and in fact, the whole world, and

WHEREAS, The specialty of anesthesiology is

growing in the number of physicians engaged in it with some 45 in Mississippi, and is also assuming more importance in medical and surgical care, and

WHEREAS, The American Medical Association recognizes anesthesiology as a section within the association and by maintaining an official liaison between the American Society of Anesthesiology and the American Medical Association, and

WHEREAS, The other states recognize the specialty of anesthesiology as a section within their state medical society, and

WHEREAS, The state of Mississippi recognizes the specialty of anesthesiology as an integral part of medical education in the University Medical School, and also as a department in the University Medical Center, and

WHEREAS, The Mississippi State Society of Anesthesiology is desirous of coordinating its annual meeting with the meeting of the Mississippi State Medical Association thereby strengthening the meetings of both organizations, be it therefore

Resolved, The Mississippi State Medical Association recognizes the specialty of anesthesiology as a section within the association, and

Resolved, The Mississippi State Society of Anesthesiology be made part of the Mississippi State Medical Association as a section, and

Resolved, The Mississippi State Society of Anesthesiology be accorded all the privileges of a section of the Mississippi State Medical Association, and

Resolved, The Mississippi State Society of Anesthesiology be required to accept and abide by the rules and regulations of a section of the Mississippi State Medical Association.

REPORT OF THE COUNCIL ON CONSTITUTION AND BY-LAWS

This resolution proposes to establish a section on anesthesiology as one of the scientific sections of the association under requirements of Chapter IV, MSMA By-Laws. In discussion before your reference committee it was recommended that all of the resolve clauses contained in Resolution No. 4 be stricken except for the following resolve:

Resolved, That the Mississippi State Medical Association recognizes the specialty of anesthesiology as a scientific section within the association.

Your council is in accord with this recommended amendment and we are in accord with the resolution as amended. We recommend adoption of Resolution No. 4 as amended.

The report of the reference committee was adopted.

RESOLUTION NO. 5, REPEAL OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Dr. Wallace E. Calhoun:

WHEREAS, The Professional Standards Review Organization contained in Public Law 92-603 is offensive because it allows peer review only when it is in accordance with HEW bureaucratic liking and thus injects third party intrusion into the practice of medicine; and

WHEREAS, The Professional Standards Review Organization Law has a potential deleterious effect on the quality, confidentiality, and cost of medical care; and

WHEREAS, It is the considered opinion of this House of Delegates that the best interests of the public will be served by repeal of the Professional Standards Review Organization Law; now therefore be it

Resolved, That the Mississippi State Medical Association House of Delegates concur with the American Medical Association House of Delegates and go on record as opposing peer review in the form of PSRO and call upon the entire Mississippi Congressional Delegation to seek repeal of PSRO.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Resolution No. 5. For the reasons stated in discussion of Resolution No. 2, we recommend that this resolution be not adopted.

The report of the reference committee was adopted.

RESOLUTION NO. 6, PATIENT RESPONSIBILITY

Dr. Donald R. Ellis:

WHEREAS, The physicians of this state and our state medical societies are totally dedicated to providing the best possible medical care for our patients; and

WHEREAS, The key to the best possible care is the doctor-patient relationship no matter what social-economic situation prevails; and

WHEREAS, The problems of medical care are compounded geometrically when a third party intrudes into this relationship; and

WHEREAS, Many years of experience in many different socio-economic situations have invariably demonstrated that intrusion into this relationship by nonmedical personnel results in an almost total collapse of effective therapy for the patient; and

WHEREAS, There is a widespread struggle within medicine and between organized medicine and innumerable outside groups over control of the practice of medicine; and

WHEREAS, The doctor-patient relationship is the key to therapy, control of medical care must rest at that level; i.e., by the patient and by his physician; and

WHEREAS, There is needless confusion between the concept of providing the best possible medical care and the problems of controlling or financing medical care; and

WHEREAS, The varied forms of medical care such as military, charity, prepaid plans, University Medical Center medicine, have all demonstrated that effective therapy requires responsibility on the part of the patient; and

WHEREAS, The social milieu of nonresponsibility has spread into medical care leading to great expectations completely free of responsibility; and

WHEREAS, The commercial insurance carriers and similar agents are using their financial involvement as a wedge to control medical care; and

WHEREAS, The present trend toward total financial coverage is basically poor medicine, and from the insurance point of view, actuarially unsound; and

WHEREAS, Many insurance companies exert great sales pressure to sell multiple coverage then deny overlapping payment even though the patient has faithfully paid several full premiums; and

WHEREAS, Sound medical care, actuarially sound insurance programs are possible if the patient is held responsible, the insurance company required to sell policies providing exact benefits for exact, specific services; these benefits to be paid regardless of cost to patient or multiple coverage; and

WHEREAS, Our own Mississippi Foundation for Medical Care is now in the process of negotiating with commercial carriers to guarantee them protection that is denied the patient and the physician; therefore be it

Resolved, That our state medical association direct its subsidiary, the Mississippi Foundation for Medical Care, to cease and desist in these negotiations that are undermining the medical care of our patients and giving the insurance carriers a distinct financial advantage at the expense of the patients and physicians of this state; and be it further

Resolved, That our society and the American Medical Association mount a massive educational program concerning the need for patient responsibility in proper medical care; and be it further

Resolved, That organized medicine realize that improved medical care comes only from better trained physicians dealing with better educated patients in a doctor-patient relationship free of outside control; and be it further

Resolved, That adequate attention be given to the fact that 95 per cent to 97 per cent of all physicians provide excellent care and that efforts toward improving the 3 per cent to 5 per cent not destroy the majority.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered this resolution which calls for the association to direct the Mississippi Foundation for Medical Care to cease negotiations with commercial carriers and to mount a massive educational program concerning the need for patient responsibility. It also resolves that attention be given to the fact that 95 per cent to 97 per cent of all physicians provide excellent care. The Mississippi Foundation for Medical Care was established among other reasons to represent the practicing physician and the public in improving health insurance policies offered by commercial carriers and Blue Cross/Blue Shield. As noted in our president's address only some one-third of personal health care expenditures in 1973 were paid for directly by patients. The foundation has also been concerned with peer review and documentation of the excellent care provided by physicians. Your reference committee recommends that Resolution No. 6 be not adopted.

The report of the reference committee was adopted.

RESOLUTION NO. 7, ADMISSION LAWS TO MENTAL HOSPITALS

Dr. Arthur A. Derrick:

WHEREAS, The admission laws to mental hospitals in Mississippi have not been modernized in recent history; and

WHEREAS, There should be a realistic balance between the rights of the individual to freedom from involuntary confinement without due process and the right of the individual, his family, and community to seek and receive help for mental illness; now therefore be it

Resolved, That the Mississippi State Medical Association furnish leadership in initiating a study and recommendations for modernizing the admission laws to mental hospitals in Mississippi; and be it further

Resolved, That a committee composed of con-

cerned physicians, lawyers, chancery court clerks, legislators, and jurists be invited to convene by the Mississippi State Medical Association for this purpose.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 7, introduced by Dr. Arthur A. Derrick, President, Mississippi State Medical Association. That resolution states:

"*Resolved,* That the Mississippi State Medical Association furnish leadership in initiating a study and recommendations for modernizing the admission laws to mental hospitals in Mississippi, and be it further

"*Resolved,* That a committee composed of concerned physicians, lawyers, chancery court clerks, legislators, and jurists be invited to convene by the Mississippi State Medical Association for this purpose."

In considering this resolution it was brought to your reference committee's attention that legislation has previously been drafted and introduced in the Mississippi Legislature which would up-date our current laws relative to commitment procedures to mental institutions. It was also noted that this legislation, although acceptable to the acknowledged experts in the mental health field, has not been acted on favorably by the legislature due to the fact that the creation of a State Department of Mental Health and Mental Retardation was considered the first priority. With the enactment of laws creating a State Department of Mental Health and Mental Retardation in the 1974 legislative session, the passage of laws modernizing our commitment procedures is considered to be the next step in revitalizing our mental health delivery system. In view of the fact that acceptable legislation to up-date our commitment procedures has already been drafted, your committee recommends adoption of the following substitute resolution:

"*Resolved,* That the Mississippi State Medical Association furnish leadership and support of legislation which would modernize our current admission laws to mental hospitals in Mississippi."

The report of the reference committee was adopted.

RESOLUTION NO. 8, MODERATION IN INCREASING PROFESSIONAL FEES

Dr. J. Dan Mitchell:

WHEREAS, The Economic Stabilization Act expired on April 30, 1974, thereby freeing the medical profession from the discriminatory controls which were placed on fees for medical services; and

WHEREAS, The abandonment of these controls now gives the individual physician the freedom to increase his fees in cases where severe and unjustified personal loss and deprivation has occurred; and

WHEREAS, In our present inflationary economy, this freedom carries with it the need for restrained and reasonable action and that the lifting of these controls be considered as both an opportunity and responsibility; and

WHEREAS, Physicians have a responsibility to their patients as well as their profession and that the political, economic and personal consequences of fee adjustment must be considered; and

WHEREAS, Impulsive action could seriously and irreversibly affect the health of the public, the future of the individual physician, and the nature of the medical profession; therefore be it

Resolved, That the medical profession should exert every effort to combat inflation by voluntarily contributing its best efforts to restrain rising costs to the greatest extent possible and, consistent with our determination to deliver the finest medical care possible to the public, that fees be increased only to the extent necessary to keep pace with inflation.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee received Resolution No. 8 which resolved that the medical profession exert every effort to combat inflation by voluntarily contributing its best efforts to restrain rising costs. We recommend adoption of this resolution.

The report of the reference committee was adopted.

RESOLUTION NO. 9, LIFE SPAN FOR CPD

Dr. Tom H. Mitchell:

WHEREAS, human blood is difficult to obtain, and

WHEREAS, The hospitals and physicians of Mississippi are needing ever increasing amounts, and

WHEREAS, That blood preserved in citrate phosphate dextrose has been scientifically shown to have a 28 day long shelf life, and

WHEREAS, The U. S. Food and Drug Administration has repeatedly deferred the licensing of CPD preserved blood for 28 days, and

WHEREAS, The state of Massachusetts and the various provinces of Canada have by law established a 28 day life-span for CPD preserved blood, and

WHEREAS, The American Association of Blood

Banks has recognized such state laws, now therefore be it

Resolved, That the Mississippi State Medical Association seek enactment of a law in Mississippi allowing for a 28 day life-span for CPD preserved blood in hospital blood banks.

REPORT OF THE REFERENCE COMMITTEE ON MEDICAL PRACTICES

Your reference committee considered Resolution No. 9, introduced by Dr. Tom Mitchell, Delegate from West Mississippi Medical Society. The resolution states:

"Resolved, That the Mississippi State Medical Association seek enactment of a law in Mississippi allowing for a 28 day life span for CPD preserved blood in hospital blood banks."

In considering this resolution it was brought to your reference committee's attention that the American Association of Blood Banks recognizes state law which extend the life span of blood from 21 days to 28 days. In view of the fact that the availability of blood is a vital and necessary aspect of medical care, your committee recommends that this resolution be referred to the Council on Legislation for introduction in the 1975 session of the Mississippi Legislature.

The motion was made by Dr. J. Dan Mitchell, Jackson, seconded by Dr. Moncure Dabney, Crystal Springs, and carried, that the Resolve clause be amended to read:

Resolved, That the Mississippi State Medical Association seek enactment of a law in Mississippi allowing for a 28 day life span for CPD preserved blood in hospital and community blood banks approved by the American Association of Blood Banks.

Dr. Van Philpot, Houston, stated that the resolution had been adopted by the Mississippi Association of Pathologists.

The report of the reference committee was adopted as amended.

RESOLUTION NO. 10, REPEAL OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Dr. Max Pharr:

WHEREAS, Professional Standards Review Organizations (PSRO) became law on Oct. 30, 1972, with the passage of Public Law 92-603, and

WHEREAS, Section 249F of P. L. 92-603 places the ultimate control of the practice of private medicine in the hands and at the whim of the Secretary of the Department of Health, Education, and Welfare (HEW), and

WHEREAS, All PSRO councils, committees, participants, etc. by whatever title and whatever their composure (physicians, laymen, bureaucrats, inspectors, nurses, coordinators, reviewers, patients, "consumers," intermediaries, agents, etc.) will merely be agents of the Secretary of HEW, and

WHEREAS, The distorted half truth and falsehood arguments of the proponents of PSRO actually in truth support this resolution for *REPEAL OF PSRO,* and

WHEREAS, The traditional and historically effective internal discipline within the fraternity of physicians will be preempted by the imposed political spoils systems of bureaucratic regimentation deceptively labeled "peer" review, and

WHEREAS, As of April 18, 1974, 15 state medical societies had resolved in favor of *REPEAL OF PSRO* Section of P. L. 92-603, and

WHEREAS, On Dec. 6, 1973, the House of Delegates of the American Medical Association in Anaheim, California, resolved in favor of *REPEAL OF PSRO,* and

WHEREAS, At least two of the Mississippi delegation to the U. S. House of Representatives signed the Open Letter to the House of Delegates of the American Medical Association urging that body to resolve for *REPEAL OF PSRO,* and

WHEREAS, There are pending in the Congress of the United States at least 50 bills for *REPEAL OF PSRO,* and

WHEREAS, There are many county medical societies that have resolved for *REPEAL OF PSRO,* and

WHEREAS, There are numerous medical staffs of hospitals that have resolved for *REPEAL OF PSRO,* and

WHEREAS, The Central Medical Society, a component of the Mississippi State Medical Association, overwhelmingly resolved on April 2, 1974, by a vote of 35 to 14 for *REPEAL OF PSRO,* said CMS comprising approximately 35 per cent of the membership of the MSMA, and

WHEREAS, Several state legislatures have resolved for *REPEAL OF PSRO,* and

WHEREAS, The Association of American Physicians and Surgeons has brought suit against the Secretary of HEW on grounds of unconstitutionality, and

WHEREAS, The delegates of the Central Medical Society to this House of Delegates of the Mississippi State Medical Association were instructed to introduce this resolution, now therefore be it

Resolved, That the House of Delegates of the Mississippi State Medical Association in regular session assembled on May 6, 1974, in Biloxi does forthrightly, unequivocally, and directly stand for total *REPEAL OF PSRO* and any substitute variations thereof, and be it further

Resolved, That this House, to be consistent and single purposed and single faced with this stand for total *REPEAL OF PSRO* does direct that all activities of the MSMA and its foundation, committees, board of trustees, central office, officers, employees, etc., by whatever title called, that are inconsistent with this stance of *REPEAL OF PSRO* shall cease immediately, and be it further

Resolved, That the delegates from the Mississippi State Medical Association to the House of Delegates of the American Medical Association are hereby instructed to convey this resolution for *REPEAL OF PSRO* to the AMA House of Delegates *and* are further instructed to introduce a resolution worded in all aspects as this resolution, into the AMA House of Delegates *and* are further instructed to work tirelessly and unequivocally for its passage, and be it further

Resolved, That separate copies of this resolution for *REPEAL OF PSRO* be forwarded under registered mail to the president of the American Medical Association, the *president-elect* of the American Medical Association, the speaker of the house of the American Medical Association, each member of the U. S. Senate and U. S. House of Representatives, to the governor of the State of Mississippi, the president of the Senate and speaker of the House of Representatives of the Mississippi State Legislature.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND BOARD OF TRUSTEES

Your reference committee considered Resolution No. 10. For the reasons stated in discussion of Resolution No. 2, we recommend that this resolution be not adopted.

The report of the reference committee was adopted.

OFFICIAL ATTENDANCE

The official attendance was announced as being 787 to include 378 members, 50 M.D. guests, 21 interns, residents and medical students, 30 non-M.D. guests, 108 exhibitors, 193 Auxiliary members and 7 staff.

REPORT OF THE REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Conduct of Business. Your reference committee commends the speaker and vice speaker for the outstanding manner in which they have conducted business before this House of Delegates. We believe that all members will wish to associate themselves in this expression of appreciation.

Resolution. The reference committee desires to offer the following resolution for consideration by the House of Delegates:

WHEREAS, The 106th Annual Session of the Mississippi State Medical Association has been conducted at Biloxi, Mississippi, during the period May 6-9, 1974, and

WHEREAS, The annual session has been most profitable and enjoyable for all who have been in attendance, now, therefore, be it

Resolved, That expressions of deep appreciation are made to the officers, Trustees and Council on Scientific Assembly for the stimulating and worthwhile scientific programs; to the management of the Sheraton-Biloxi and to other participating hotels and motels; to the press, radio and television for coverage of our activities; to the gracious ladies of the Auxiliary who always contribute so substantially to our meetings; to the technical exhibitors and their professional service representatives; to our scientific exhibitors who have contributed to our learning and instruction; to our distinguished guests, particularly Dr. Russell B. Roth of Erie, Pennsylvania, president of the American Medical Association; and to all who have shared in the responsibilities of planning, organizing and conducting this great annual session.

Your reference committee recommends adoption of this resolution.

The report of the reference committee was adopted.

REPORT OF THE ELECTION OF OFFICERS

President-elect: Jack A. Atkinson, Brookhaven.

Vice Presidents: Whitman B. Johnson, Clarksdale; William B. Hunt, Grenada; and Paul H. Moore, Pascagoula.

Delegate to AMA: Joseph B. Rogers, Oxford (1976).

Alternate Delegate to AMA: Arthur E. Brown, Columbus (1976).

Editor: W. Moncure Dabney, Crystal Springs (1976).

Associate Editor: George H. Martin, Vicksburg (1976).

Board of Trustees: Arthur A. Derrick, Durant, Dis-

trict 4; Carl G. Evers, Jackson, District 5; and Joe S. Covington, Meridian, District 6 (1977).

Council on Budget and Finance: Gerald P. Gable, Hattiesburg (1977).

Council on Constitution and By-Laws: W. Lamar Weems, Jackson (1977).

Judicial Council: Gerald A. Smith, Sumner, District 1; John R. Lovelace, Batesville, District 2; and Frank M. Davis, Corinth, District 3 (1977).

Council on Legislation: James V. Ferguson, Jr., Greenwood, District 1; David A. Ball, Batesville, District 2; and William H. Preston, Jr., Booneville, District 3 (1977).

Council on Medical Education: Carl G. Evers, Jackson (1977).

Council on Medical Service: Ed Pennington, Ackerman, District 4; Tom H, Mitchell, Vicksburg, District 5; and William M. Gillespie, Jr., Meridian, District 6 (1977).

State Board of Mental Health (On recommendation of the Nominating Committee, the House of Delegates formally submitted the following names to the Governor for his consideration in appointing the State Board of Mental Health): Victor Landry, Lucedale; R. P. White, Meridian; Charles Hubbert, Oxford; William E. Bowlus, Jackson, and Arthur W. Lindsey, Cleveland.

OTHER BUSINESS

Drs. Arthur A. Derrick, Durant, and C. D. Taylor, Pass Christian, presented the following resolution to lie on the table for one year:

WHEREAS, Gross inequity existed and still exists as to association district representation on the Board of Trustees, and

WHEREAS, Any realignment plan that disrupts component societies will never be satisfactory to all concerned, now therefore be it

Resolved, That the following clause of Section 8, Chapter VIII By-Laws of Mississippi State Medical Association be stricken ". . . provided that all counties in a component society shall be in one Association District . . ." and be it further

Resolved, That the districts be defined as follows:

District 1: Bolivar, Coahoma, Humphreys, Issaquena, Leflore, Quitman, Sharkey, Sunflower, Tallahatchie, Tunica, Washington, and Yazoo.

District 2: Alcorn, Benton, Calhoun, DeSoto, Itawamba, Lafayette, Lee, Marshall, Panola, Pontotoc, Prentiss, Tate, Tippah, Tishomingo, Union, and Yalobusha.

District 3: Chickasaw, Clay, Kemper, Lauderdale, Lowndes, Monroe, Neshoba, Newton, Noxubee, Oktibbeha, and Winston.

District 4: Attala, Carroll, Choctaw, Clairborne, Grenada, Holmes, Leake, Madison, Montgomery, Rankin, Scott, Simpson, Smith, Warren, and Webster.

Districts 5 and 6: Hinds.

District 7: Clarke, Forrest, George, Greene, Jasper, Jones, Perry, Stone, and Wayne.

District 8: Adams, Amite, Copiah, Covington, Franklin, Jeff Davis, Jefferson, Lamar, Lawrence, Lincoln, Marion, Pearl River, Pike, Walthall, and Wilkinson.

District 9: Hancock, Harrison, and Jackson.

The invocation at the House of Delegates meeting on May 9, 1974, at 1:30 o'clock was given by Dr. James T. Thompson of Moss Point. The Reference Committee on Credentials reported the quorum of 92 registered and seated delegates.

CLOSING CEREMONIES

There being no further business, the speaker returned the gavel to President Derrick. The Oath of Office was administered to Dr. J. T. Davis, the president-elect, by Dr. James O. Gilmore, chairman of the Board of Trustees, after which Dr. Davis addressed the House of Delegates.

Mrs. James Grant Thompson of Jackson presented the Thompson Memorial Past President's Pin to Dr. Derrick.

The House of Delegates was adjourned *sine die* at 4:15 o'clock in the afternoon, May 9, 1974.

A Summary of the 51st Annual Session of the Woman's Auxiliary to the Mississippi State Medical Association

May 6-9, 1974
Biloxi, Mississippi

PRECONVENTION BOARD MEETING

The meeting was called to order at 2:00 p.m., May 6, 1974, in the Jackson Room of the Sheraton-Biloxi by the president, Mrs. William H. Preston, Jr., of Booneville. Mrs. A. T. Tatum of Hattiesburg gave the invocation. There were 30 members present.

After minutes were approved, Mrs. Preston introduced the president-elect, Mrs. Dan Reikes of Hattiesburg and recognized the following convention chairmen: Mrs. Jack Stokes of Pontotoc, General Chairman; Mrs. John Estess of Hollandale, Registration; Mrs. T. A. Baines of Jackson, Hospitality; Mrs. Lee Rogers of Tupelo, Luncheon; and Mrs. John Green and the Hattiesburg Auxiliary, hostesses for the MSMA Welcome Booth.

A special welcome was extended to Mrs. Willard C. Scrivner of Belleville, Ill., president of the Woman's Auxiliary to the AMA.

The Board voted to support: (1) the motion made by Mrs. H. H. McClanahan of Columbus to cancel the continental breakfast prior to the general meeting so that members could join their husbands at the General Membership Breakfast; and (2) the motion made by Mrs. A. T. Tatum of Hattiesburg to recommend the report of the Finance Committee.

Mrs. Frank Acree of Greenville reported on the County Leadership Conference in Chicago and offered materials and information.

After convention announcements, members were reminded of the poolside coffee honoring unit presidents, and the meeting was adjourned at 3:25 p.m.

FIFTY-FIRST ANNUAL MEETING

The fifty-first annual meeting of the Woman's Auxiliary to the Mississippi State Medical Association was called to order on May 7, 1974, at 9:30 a.m. in Gulf Rooms A and B, The Sheraton-Biloxi, by the president, Mrs. William H. Preston, Jr., of Booneville.

The invocation was spoken by Mrs. Sam Rowlett of Vicksburg and Mrs. Preston led the auxiliary pledge. Mrs. William Clement of Gulfport welcomed members, and the response was made by Mrs. S. J. McDuffie of Nettleton. A list was passed to record delegates in lieu of roll call.

Mrs. Preston recognized the president-elect, Mrs. Dan Reikes of Hattiesburg, and welcomed Mrs. Willard C. Scrivner of Belleville, Ill., president of Woman's Auxiliary to AMA; Mrs. W. Nash Thompson of Stuart, Va., president of Southern Medical Auxiliary; Dr. Arthur Derrick, president of MSMA, and Mrs. Derrick; Dr. J. T. Davis of Corinth, president-elect of MSMA, and Mrs. Davis. Dr. Derrick, Dr. Davis and Mrs. Thompson brought official greetings to the assembly.

Mrs. Jack Stokes of Pontotoc, general chairman of the convention committee, reported 148 registered members. (The final count of registered members was 193.)

Mrs. William Bowlus of Jackson conducted a memorial service for auxilians, Mrs. William R. Lockwood and Mrs. Thomas G. Ross, members of Central Medical Auxiliary.

A special presentation of the AMA-ERF grant check for $9,628.91 from MSMA and Woman's Auxiliary to MSMA to the University of Mississippi School of Medicine was made. Those participating were Dr. Derrick, Dr. Carl Evers, representing the University of Mississippi School of Medicine, Dr. John McRae, president of the University of Mississippi Medical Alumni, Mrs. Edward Hill, AMA-ERF chairman, and Mrs. Preston.

Mrs. Scrivner, featured speaker for the meeting and bearer of official greetings, congratulated Mississippi for its contribution to AMA-ERF, encouraged the auxiliary to continue its work with child abuse, to keep informed on legislation and to strive to enroll all doctors' wives as auxiliary members. She gave enlightening details of the national auxiliary program.

Mrs. Charles Thompson of Columbia, co-chairman of the Archives and History Committee, made the formal presentation of the Fifty Year History and informed members that publication was scheduled for the fall of 1974. She reminded that the history is the story of the work of the auxiliary and hoped it would be used to inspire continuing good work and to promote better public relations.

Chairman of the Archives and History Committee, Mrs. T. A. Baines of Jackson, reported on the progress of the Fifty Year Commemorative Quilt and invited auxilians to view the quilt after the general meeting.

A motion made by Mrs. George Owen of Jackson to dispense with the reading of the minutes of the 50th Annual Meeting, which had been distributed, was carried.

President's Report: Mrs. Preston summarized the work of the Mississippi Medical Auxiliary for 1973-74, which was highlighted by attention to programs supporting health education and services for venereal disease, drug abuse, child abuse, postnatal child care and nutrition. She noted continued sponsorship of AMA-ERF, nurses' loan funds, "Pierre the Pelican," recruitment of medical personnel, and strides in understanding medical legislation. She reported a significant increase in membership. She stressed the need for better communication among auxilians and the importance of letting the work of the auxiliary be better known. She expressed hope that re-dedication earlier in the year to our husbands' profession had strengthened our contribution and our influence as doctors' wives.

Treasurer's Report: The treasurer, Mrs. Henry Webb of Jackson, informed members that the 1973-74 budget based on 980 paid members at the time of the 1973 convention, together with a treasury surplus for 1972-73 and supplements for DISTAFF and convention from MSMA, came to a total of $4,439.19 for money received. The total for budget disbursements and disbursements from surplus and supplemental funds amounted to $4,031.27, leaving a treasury surplus of $407.92. Paid dues received to date for 1,050 members @ $3.00 each is $3,150.00, leaving a year and checkbook balance of $3,557.92, which balance is subject to the addition of late dues, the cost of the commemorative quilt and other disbursements until the time books are closed in June 1974.

Finance Committee Report: Mrs. Henry Webb, reporting for Mrs. David Wilson, presented the budget for 1974-75. The 1974-75 budget is based on 1,050 paid members @ $3.00 each, which gives a total of $3,150.00.

Mrs. Arthur Brown of Columbus made the motion to adopt the budget for 1974-75, and the motion was carried.

DISTAFF: Mrs. Henry Webb, reporting for Mrs. George Taylor, editor: DISTAFF expenses for the 1973-74 auxiliary year (including postage and mailing fees, supplies, and cost of printing for three issues) came to a total of $809.12.

Pierre the Pelican Fund: Mrs. Henry Webb, reporting for Mrs. Clarence Webb, Jr.: Contributions for "Pierre the Pelican," a health education pamphlet series project, which are deposited in a separate account, were received from seven auxiliaries, with an additional contribution from the Preventorium Fund, and came to a total of $1,547.00. Added to contributions received during 1972-73 for $300.00 and interest, gives a final total of $1,885.84.

Nurses Loan Fund: A current balance of $701.85 was reported in the state nurses loan fund account, with one nurse paying back a loan, and four auxiliaries having contributed to the fund in 1973-74.

Preventorium Fund: Mrs. A. T. Tatum of Hattiesburg reported a disbursement of $500.00 to the Archives and History Committee toward publication of the Fifty-Year History and a balance on hand of $5,228.34.

Other chairmen giving reports were Mrs. H. H. McClanahan, who encouraged members to join AMPAC-MPAC; Mrs. T. Lowell Ketchum, Legislation, who reported a successful statewide legislative alert; Mrs. T. E. Ross, III, Southern Medical Counselor, who brought news from the meeting of SMA; and Mrs. Milam Cotten, Doctors' Day, and Mrs. Edward Hill, AMA-ERF, who reminded members that awards would be given at the luncheon.

Using visual aids and original presentations, the following unit presidents gave reports: Mrs. John Estess, Washington County; Mrs. Lee Rogers, Northeast; Mrs. Paul Brumby, North Central; Mrs. Louis Farber, Central; Mrs. Sam Rowlett, West Mississippi; Mrs. John Green, Hattiesburg; Mrs. Donald Barraza, Adams County; Mrs. William R. Clement, Gulfport; Mrs. William Warfield, Singing River.

Delegates to the annual meeting of Woman's Auxiliary to AMA were appointed: Mrs. Dan Reikes, Hattiesburg, presidential delegate; Mrs. Edward Hill, Hollandale, chairman; Mrs. S. J. McDuffie, Nettleton, and Mrs. Frank Acree, Greenville.

Nominating Committee Report: Mrs. Robert Middleton of Biloxi presented the slate of officers for 1974-75. As there were no nominations from the

floor, Mrs. George Owens made the motion that the slate of officers be accepted. The motion was carried.

Officers for 1974-75: Mrs. Dan Reikes of Hattiesburg, president; Mrs. Edward Hill of Hollandale, president-elect; Mrs. Joe Herrington of Natchez, first vice-president; Mrs. Thomas Blake of Jackson, second vice-president; Mrs. Patrick Pierce of Long Beach, third vice-president; Mrs. John Green of Hattiesburg, fourth vice-president; Mrs. William Hilbun of Meridian, recording secretary, and Mrs. Moncure Dabney of Crystal Springs, treasurer.

Mrs. T. E. Ross, III, introduced Mrs. W. Nash Thompson, who presided over the installation of officers.

Following the adoption of the Courtesy Resolution, which was presented by Mrs. Curtis Caine of Jackson, the meeting was adjourned at 12:05 p.m.

ANNUAL GALA LUNCHEON

The annual luncheon of Woman's Auxiliary to MSMA honoring past state presidents, was held on May 7, 1974, at 1:00 p.m., Top of the Sheraton, with the president, Mrs. Preston, presiding.

Mrs. Joe Herrington of Natchez gave the invocation. Mrs. Preston recognized Mrs. Willard Scrivner, president of Woman's Auxiliary to AMA, and Mrs. W. Nash Thompson, president of Southern Medical Auxiliary, who brought official greetings. Individual recognition was given to the 25 past presidents of Woman's Auxiliary to MSMA who were present, and hostesses pinned a rose on each.

Mrs. Lee Rogers of Tupelo, Luncheon Chairman, introduced the program, a delightful style show featuring doctors' wives as models.

Mrs. Scrivner, the luncheon speaker, was both inspirational and challenging.

Mrs. Preston introduced the new officers for 1974-75. She presented the president's pin and the gavel to incoming president, Mrs. Dan Reikes of Hattiesburg, who proposed the theme, "We Care," for the coming year and closed her response with a unique prayer.

Awards: AMA-ERF Awards were given by Mrs. Edward Hill, chairman, to Amite County, Adams County (Homochitto), Northeast, and Hattiesburg. Doctors' Day Awards were presented by Mrs. Milam Cotten, chairman, to Hattiesburg, Singing River and Homochitto.

Mrs. Preston thanked Mrs. Rogers and the Northeast Auxiliary for the lovely luncheon. The program was concluded with the presentation of the past president's pin to Mrs. Preston by Mrs. Paul Brumby of Lexington and the luncheon was adjourned at 2:50 p.m.

POST CONVENTION BOARD MEETING

Mrs. Dan Reikes of Hattiesburg, president, called the meeting to order at 3:30 p.m. on Tuesday, May 7, in the Jackson Room of the Sheraton-Biloxi. She appointed the corresponding secretary, the parliamentarian, and committee chairmen for 1974-75.

Workbooks were distributed and the yearly theme, "We Care," was discussed with challenges for the new year.

The Board voted, because of rising costs, to reduce the DISTAFF from three issues annually to two issues with a president's newsletter in January.

Members were reminded of the next meeting of the Board of Directors in Jackson on Aug. 13, 1974, and the meeting was adjourned.

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SEPTEMBER 1974

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Volume XV
Number 9
September 1974

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
September 1974, Vol. XV, No. 9

ORIGINAL PAPERS

Gout: New Observations on an Old Disease

THOMAS E. WEISS, M.D. and
NANCY E. TONDREAU, M.D.
New Orleans, Louisiana

INTEREST IN gout remains intense and widespread, even though significant progress has been made in sorting out some of its causes and its therapy. Because of its association with some newly discovered inborn errors of metabolism, its secondary association with many conditions, man's poor acceptance of continuous treatment of a chronic, painless disease, and lastly, but most significantly, our persistent paucity of knowledge, it remains a medical challenge.

With the widespread use of multiple channel autoanalyzers for serum chemical determinations and the administration of numerous drugs that elevate serum uric acid levels, not a small number of people are incorrectly diagnosed as having gout and at the same time many cases of previously unrecognized gout are diagnosed. An elevated serum uric acid level alone does not necessarily mean gout, nor does it always justify a lifetime of drug or dietary therapy to try and attain a normal serum uric acid level.

Hyperuricemia and gout are not the same. For this discussion hyperuricemia implies a serum uric acid level above 8 mg/100 ml for the adult male, but in actual fact it is impossible to define the limits of hyperuricemia and some investigators have felt that two standard deviations above the mean would be the best way to establish a level. Hyperuricemia is an elevated serum uric acid chemical state that may be due to many causes but is usually asymptomatic. Gout is a disease marked by hyperuricemia where acute or chronic arthritis, sodium urate tophi, uric acid, renal calculi, and urate nephropathy may be present.

Recent advances in gout research have partially clarified our understanding of this old disease. Frequent measurement on autoanalyzers of serum uric acid levels and recognition of many drugs that cause hyperuricemia require diagnostic precision. [Secondary] hyperuricemia is caused by many diseases and gout itself is associated with hypertensive cardiovascular disease. Platelet abnormalities in gouty patients have been described. Genetic defects causing gout may be diagnosed in several ways. The complex role of the kidney in handling urates has been studied in detail, as have the effects of gout on the kidneys.

Because an elevated serum uric acid level is a common denominator of both conditions, the distribution of its incidence in the population affords added information. In the Framingham Heart Study a patient getting an attack of gout with a serum uric acid level of 9 mg/100 ml or higher rather than a level of 7 mg/100 ml or lower was a much higher risk. Other findings of the Framingham study demonstrate that there is *no* critical serum uric acid level above which gout always occurs.

In normal man the biosynthesis of purine is a complex system that has feedback inhibition, an

Presented at the Mississippi-Louisiana Meeting of the American College of Physicians, Biloxi, Miss., Feb. 15-16, 1974.
From the Section on Rheumatology, Ochsner Clinic and Alton Ochsner Medical Foundation, New Orleans, La.

enzyme (HG-PRTase) that catalyzes hypoxanthine to form more inosinic acid and another enzyme that degrades xanthine and hypoxanthine into the end stage product that is uric acid. Figure 1 is a simplified scheme of purine synthesis and breakdown. Deficiencies have been demonstrated in hypoxanthine-guanine phosphoribosybyl transferase (HG-PRTase) of all the tissues of children with a syndrome now known as the Lesch-Nyhan or sex-linked aciduria illness. These children have an extremely high serum uric acid level, mental deficiencies or defects, oftentimes muscle spasms, and a unique tendency to self-mutilation, particularly of the lips, tongue, and fingers. A less complete form of HG-PRTase deficiency has been described in at least 28 to 30 older patients. All have very high serum uric acid levels, a history of early onset of gout, severe joint and renal involvement, and kidney stones. Mild types of neurologic abnormalities do occur.

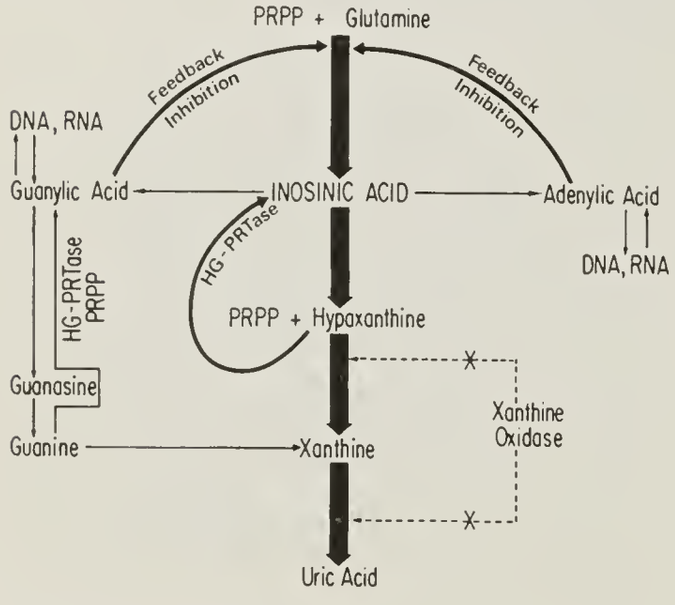


Figure 1. Simplified scheme of purine biosynthesis.

The prenatal diagnosis of a Lesch-Nyhan syndrome is advisable and amniotic cells obtained in mid-stage of gestation can be cultured and examined for this enzymatic deficiency. Another test that may disclose which children are affected is a test of the urine to determine the ratio of urinary uric acid to creatinine (UA/C). This ratio is high in patients with the L-N syndrome, and if the ratio of urinary uric acid to urinary creatinine exceeds 2 on a single morning urinary specimen, the L-N defect is considered complete. A partial expression of this syndrome may be suggested in adults with gout when the UA/C ratio is above 0.75 on a 24-hour collection with the patient on a purine-free diet. False positives may occur with hyperuricemia associated with glycogen I storage and myeloproliferative diseases. This same enzymatic defect can also be identified in erythrocytes from finger sticks.

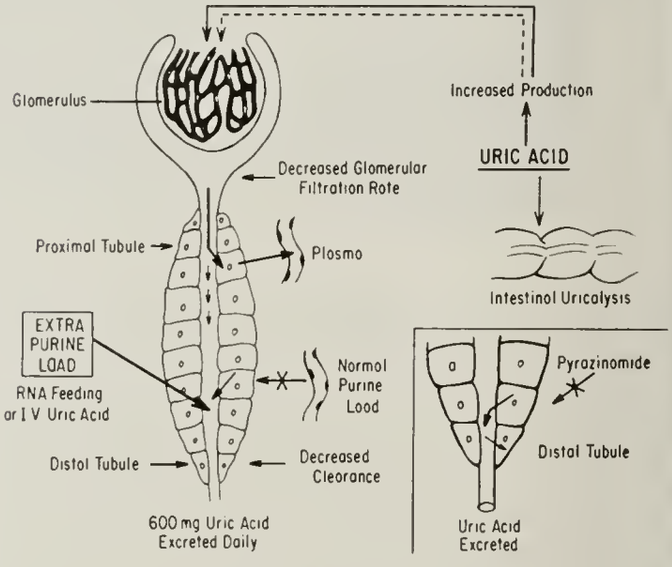


Figure 2. Renal handling of urates.

The renal handling of urates is of paramount importance and about 70 per cent of the body uric acid is excreted through the kidneys. The remainder is destroyed or degraded by intestinal uricolysis (see Figure 2). Uric acid is completely filtered at the glomerulus and in 98 to 100 per cent is reabsorbed at the proximal tubule. Decreased glomerular filtration rate may occur from renal insufficiency, myxedema, and both hyper- and hypoparathyroidism (see Table 1).

TABLE 1

RENAL HANDLING OF URATES

A. Decreased Glomerular Filtration Rate
1. Renal insufficiency
2. Myxedema
3. Hyper- and hypothydroidism
B. Decreased Clearance
1. Diuretics
2. Ketone bodies—Increased lactate
3. Aspirin (less than 40 gr)
4. Lead poisoning
5. Pyrazinamide

Urate secretion occurs at the distal tubule and with hyperuricemia the secretory rate per nephron increases. This is an important factor in monitoring homeostasis even in the face of chronic renal change. If the glomerular filtration rate falls below 10 ml/min, then there is a striking decrease in tubular reabsorption and secretion of uric acid. Consequently, this results in a more or less direct, but sharp, urate excretion per nephron as this material is neither reabsorbed nor secreted after it is filtered through the glomerulus.

As shown in Table 1, there is decreased clearance secondary to most diuretics, ketone bodies, lead poisoning, pyrazinamide, and small doses of aspirin as well as some other drugs. The distal tubule may also reabsorb some of the excreted uric acid. The function at this site is not yet fully clarified. At one time it was thought that pyrazinamide would completely block the secretion of urates at the distal tubule. Such may not be the case. The autonomic nervous system is now felt to play a role here.

Secondary hyperuricemia may be associated with renal damage, an endocrine disorder, secondary to blood dyscrasia, in drug ingestion, psoriasis, and in rare problems such as an arteriovenous fistula causing secondary polycythemia (see Table 2).

Certain chemicals, drugs, and other substances may cause an elevated serum uric acid level but this is merely a false laboratory reading and does not reflect a true hyperuricemia. A true decrease in the serum uric acid level is caused by a number of substances. The causes of both of these phenomena are summarized in Tables 3 and 4.

The dangers of gout and true hyperuricemia are in the areas of articular, renal, and vascular function. Joint damage follows gouty synovitis and tophaceous deposits in or about a joint. This usually is a prolonged process and unless corrected may even result in complete destruction of the joint.

The renal effects of gout may be the passage of "brick dust" or brownish colored urine or uric acid stones. About 20 per cent of patients with gout have uric acid stones. Even with an apparently normal excretion of urinary uric acid (less than 600 mg/100 ml), there is an above normal prevalence of uric acid nephrolithiasis. The urinary pH may be an extremely important factor in patients with uric acid nephrolithiasis. The early morning urine in these patients is likely to be unduly acid and often this tends to persist during the day. In addition, there is a 25 to 30 per cent decrease in urinary ammonia excretion where the pH is below 5.7, thus making the urine

TABLE II

SECONDARY HYPERURICEMIA

A. Renal
 1. Gouty nephropathy (deposits of monosodium urate)
 2. Lead poisoning
 3. Byrellium poisoning
B. Endocrine
 1. Myxedema
 2. Hypo- and hyperparathyroidism
 3. Idiopathic hypercalciuria
 4. Pitressin resistant diabetes
 5. Diabetes mellitus (?)
 6. Stress
C. Blood Dyscrasias (10 per cent)
 1. Leukemia
 2. Polycythemia vera
 3. Multiple myeloma
 4. Myeloid metaplasia
 5. Lymphosarcoma
 6. Hodgkin's disease
 7. Hemolytic disease
 8. Pernicious anemia
 9. Sickle cell anemia
 10. Non-tropical sprue
 11. Waldenstrom's hyperglobulinemia

 A-V fistula
 Psoriasis
D. Drug-Induced
 1. All diuretics except spironolactones and triamterenes
 Thiazides
 Mercurials
 Diamox
 Ethacrynic acid
 Chlorthalidone
 Furosemide
 2. Aspirin (low dosage)
 3. Pyrazinamide
 4. Ethambutol

TABLE III

LABORATORY HYPERURICEMIA

1. Caffeine
2. Theophylline
3. Theobromine
4. Homogentisic acid
5. Hyperglycemia
6. Chromagens in renal failure
7. Aldomet

TABLE IV

SECONDARY HYPOURICEMIA

1. Glycopyrrolate (Robinul) 2 mg orally 40-79 per cent excretion of uric acid
2. Tridihexethyl chloride (Milpath, Pathibamate, Pathilon)
3. Chlorprothixene (Taraetan)
4. Iopanoic acid (from 1 hour to 5 days)
5. Ipodate (Orografin)

much more acid. Gouty nephropathy is not the challenge to life that it formerly was, and in most gouty patients, the renal pathology is non-specific, usually reflecting the effects of vascular disease or aging.

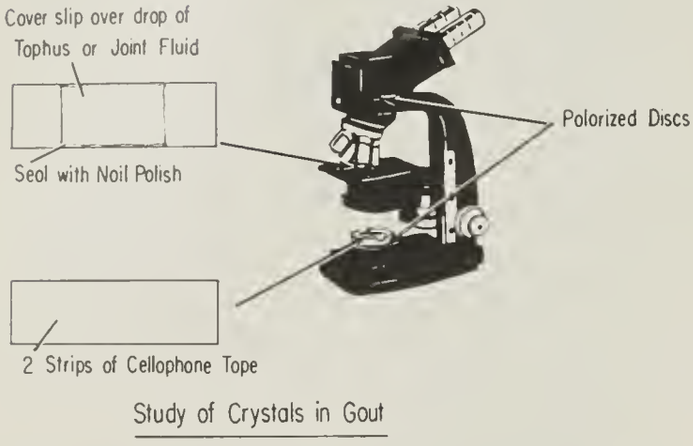


Figure 3. Method of demonstrating urate crystals in synovial fluid or tophi.



Figure 4. Urate crystals from synovial fluid.

About 30 per cent of patients with gout are hypertensive but the cause is not clear. With this goes cerebral or other vascular accidents and some effort is now being directed toward better control of the vascular state by controlling the hyperuricemia and gout. A hyperactive platelet population, that is, surface activation and aggregation, are found in at least 50 per cent of patients with primary gout. This platelet behavior may be related to hyperuricemia and may contribute to the vascular complications such as hypertension, diabetes mellitus, and hyperlipidemia. Uricosuric drugs may produce an indirect or direct inhibitory potential on platelet surface activation. Recent studies reveal that halofenate and allopurinol seem to be direct strong inhibitors of platelet activation.

The diagnosis of gout, acute or chronic, is best made by demonstrating urate crystals in synovial

TABLE V

GOUT THERAPY

Drug	*Dosage*
	Acute Gout
Colchicine	0.6 mg q 2 h until relief or toxicity (limit to 15 doses)
Phenylbutazone	200 to 300 mg immediately—repeat in 4 hrs, then 100 mg q i d × 4-6 days
Indomethacin	50 to 75 mg t i d for 2 days then 25 mg q i d × 4 days
Colchicine (IV)	2 mg followed in 1 hour by 1 mg, repeat 1-2 times if needed
Adrenocortical steroids	(oral or intraarticular)
Adrenocorticotrophic hormone	60-80 in gel intramuscularly q 12 h × 2 or 3 doses if needed
	Interval Therapy
Colchicine	0.6 mg daily or b i d
Probenecid* (in patient free of renal disease and with normal 24 hour urinary uric acid)	250 mg daily × 7 days, then 500 mg daily × 2 weeks, then increase up to 1 gm b i d
Allopurinol* (in other gout patients)	50 mg daily × 7 days, then 100 mg daily × 7 days. Increase up to 400 mg/day

Dosage depends on reduction of serum uric acid to normal. Continue indefinitely if not toxic.

Oral water intake to maintain a 2,000 cc daily urinary output.

* Salicylates and ASA should not be given continuously with uricosuric drugs as they block the action of these drugs.

fluid or tophi. This can be done as shown in Figure 3 with a drop of synovial fluid on a slide, nail polish to seal the coverslip, and a few modifications for the microscope including two small pieces of polarizing plastic, and a second slide covered lengthwise with two pieces of clear wide cellophane tape.[1]

There are several therapeutic regimens for gout. An acute attack of gouty arthritis requires treatment immediately after onset or at the patient's first "joint warning signs." The drug of choice depends on patient tolerance of side effects and of route of administration. If colchicine is used, it has an added diagnostic value when given for early attacks, but subsequent acute attacks may be managed without diarrhea by using phenylbutazone or indomethacin. Between acute attacks, patients with recurrent gouty arthritis should take maintenance colchicine and either a uricosuric drug or allopurinol. Renal disease, uric acid calculi, and/or a high urinary uric acid preclude the use of uricosuric agents. For these patients, continuous allopurinol and alkalinization of the urine with sodium bicarbonate or sodium citrate (2 gm q 4-6 hr) are preferred. Tophectomy is reserved for large uric acid deposits relatively inaccessible to the general circulation or mechanically incapacitating. Acceptable treatment schedules are given in Table 5. ★★★

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A woman with six small children tagging along said to the girl at the perfume counter, "Actually, what I need is a repellent."

New Perspectives in Hypertension

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Evaluation of blood pressure control mechanisms in normal and abnormal situations has yielded information helpful in characterizing the type of hypertension and rational therapy based not only on primary mechanisms but compensatory mechanisms brought on by drug therapy.

This paper deals with the problem of the patient with essential hypertension whose blood pressure is difficult to control. An attempt to evaluate the respective roles played by volume expansion and vasoconstriction is important in that therapy can be selected to be relatively specific depending on the dominant pressor mechanism involved.

Drug therapy also elicits hemodynamic changes which have to be taken into consideration in the development of an optimal program.

ALTHOUGH hypertension is not a new disease, certain aspects of it have been appreciated only relatively recently.

There are an estimated 20 to 25 million Americans who have hypertension and the challenge to our health, education, and medical care delivery systems is clear when it is recognized that only half of these hypertensives are detected. Of those persons who are known to have hypertension, only half are being treated and only half of the treated hypertensives are adequately controlled, based on a criterion of lowering blood pressure to a systolic level of less than 160 and a diastolic level of less than 95.[1]

The Society of Actuaries Study for 1959 showed that, for men 35 years of age with a blood pressure of 142/90 without other impairments, the mortality rate over their next 20 years was 19 per cent, as compared with 11 per cent for normotensives (standard risk). In other words, this "modest" elevation of blood pressure, which is frequently ignored, was associated with a 76 per cent higher death rate in middle age. The 10-year death rate from all causes was 60 per cent higher for men with diastolic pressures from 95 to 105 and 200 per cent higher for men with diastolic pressures of 105 or greater. When hypertension coexists with other risk factors, the risks are additive. The death rate is twice as high over their next 10 years for men aged 30 to 59 who have hypertension as the only risk factor, three times as high when hypertension coexists with smoking *or* high cholesterol, and five times as high when hypertension coexists with smoking *and* high cholesterol.

The control of normal and abnormal arterial pressure has been evaluated extensively by the elegant studies of Guyton et al[2, 3] which have indicated that the long-term regulation of blood pressure is determined by the relationship between arterial pressure and the body's balance of water and salt. With an increased cardiac output the excess blood flow (over perfusion) causes an autoregulatory response that increases arterial pressure and total peripheral resistance, i.e., arterial pressure rises first and total peripheral resistance then increases until the increased resistance reduces the cardiac output. Pressure-induced diuresis then causes the kidney to excrete the excess fluid and return the cardiac output to normal. Chronically elevated blood pressure appears to be impossible in the presence of normal renal function.

The role of the kidney in hypertension is not clearly understood but it is postulated that (1) there is a genetic predisposition to decreased renal function which either causes increased fluid volumes eliciting the autoregulator response of increased cardiac output followed by increased peripheral resistance; or

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(2) that altered renal sodium handling prevents the pressure induced diuresis that should accompany the increase in arterial pressure and peripheral resistance. As considered, peripheral resistance, cardiac output, blood volume, and extracellular fluid volume are dependent values that are adjusted upward and downward by the renal body-fluid feedback mechanism.

The estimates of the number of hypertensive patients clearly indicate that, if the undetected hypertensive population could be discovered, exhaustive studies for a secondary form of hypertension in all of these individuals would overtax existing medical facilities. For this reason, emphasis is shifting away from an exhaustive search for curable causes of hypertension in every patient. If the initial history, physical examination, and simple laboratory testing give no clues to a curable cause, it is felt appropriate to treat the individual. If the hypertension does not respond to treatment, then a more thorough diagnostic evaluation is justified.

MANAGING DIFFICULT PATIENTS

Let us assume then that we have a group of patients who have not responded to the time-honored treatment—salt restriction, diuretics, or diuretics and reserpine, and who have had curable causes like aldosteronism, pheochromocytoma, renal artery stenosis, etc., excluded. How best do we handle this group of essential hypertensive patients who are difficult to control? The first thing we would like to do is characterize their type of hypertension with particular regard to the relative roles played by vasoconstriction and volume excess. An understanding of the status of the renin-angiotensin-aldosterone axis seems to help in this regard.

The role of renin in various types of hypertension is difficult to ascertain. Renin release mechanisms are beyond the scope of this discussion but include (1) baroreceptor stimulation induced by changes in pressure differential across the afferent arteriolar wall, (2) sympathetic stimulation and (3) changes in the composition of the fluid in the distal tubule.

Repeating the Goldblatt experiments with the addition of angiotensin inhibitors or antibodies has shown that the hypertension resulting from clamping a renal artery and leaving the contralateral kidney in can be prevented by the angiotensin inhibitors or antibodies. This suggests that renin-induced changes were responsible for the hypertension and that the vasoconstrictor effect of angiotensin played a large role in the hypertension. Renin levels could thus be considered an index of vasoconstriction.

The one kidney model, i.e., clamp one renal artery and remove the contralateral kidney, developed hypertension in spite of the angiotensin antibodies, suggesting vasoconstriction was not playing a significant role in that type of hypertension. The hypertension here seemed to result from reduced nephron mass and the resultant salt and water overload.

This has suggested that analysis of renin helps characterize the role that vasoconstriction is playing in a given patient with hypertension. For any given plasma renin level to be considered normal or abnormal the state of sodium balance has to be considered. For this reason, renin values are being expressed in terms of relationship between plasma renin and concomitant sodium balance as estimated by 24-hour urinary sodium excretion when the individual is in sodium balance. It is obvious that certain dietary changes in salt or the use of diuretics are going to alter sodium balance and cloud the interpretation of renin data, as pointed out by Laragh and coworkers.[4] This renin activity compared with sodium excretion can be expressed as high, low, or normal when compared to nomograms of normal controls (see Figure 1). This type of evaluation gives a better understanding of the nature of the

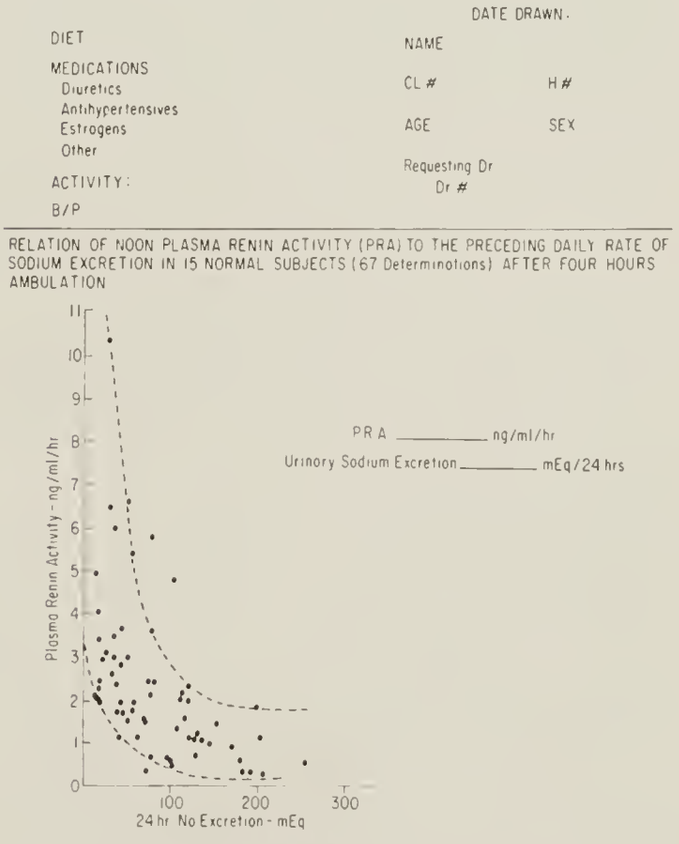


Figure 1. Graph showing the relationship of plasma renin activity to 24-hour sodium excretion in normal volunteers in sodium balance. Patient values are compared with this graph in attempt to delineate if renin is "high," "normal," or "low."

hypertension as well as diagnostic and prognostic clues and aids in the program of treatment.

Analysis of the renin status seems to give information relative to the roles played by vasoconstriction and volume in the individual types of hypertension.[5]

Vasoconstrictor hypertension (also known as high renin hypertension) is characterized by systemic vasoconstriction which is thought to be produced by renin-mediated formation of angiotensin II. Pressure-induced naturesis that would normally accompany this vasoconstriction is prevented by the sodium reabsorption from the simultaneous stimulation of aldosterone by angiotensin II and therefore the volume is maintained against an unyielding capacity. The co-factors involved here are vasoconstriction and sodium retention so the fullest expression of vasoconstrictor hypertension is malignant hypertension.

Volume hypertension (low renin hypertension), on the other hand, is characterized by hypertension that is due to a maintained excess of sodium and water. Vasoconstrictor activity (angiotensin II) is minimal or absent and renin approaches zero. The explanation for this excess volume is uncertain, but postulates include impaired ability to excrete sodium, impaired ability to excrete potassium with consequent aldosterone stimulation, high dietary salt intake, and an unidentified mineralocorticoid. The pathophysiology of low renin hypertension appears to include relatively dilated and distended arterioles due to the low vasoconstrictor activity, with high plasma and extracellular fluid volumes and therefore better perfusion and fewer complications.

Normal renin hypertension is considered by Laragh et al[5] actually to be an inappropriate vasoconstrictor-volume interaction. Fifty per cent of the essential hypertensive patients have "normal renin" and Laragh suggests that since the arterial pressure increase should suppress renin, the "normal" renin is therefore inappropriately high for the sodium balance and volume status. Some partial support for this was found by other workers[6] who have shown a lower threshold for release of renin in the majority of a group of patients studied with essential hypertension. They found in their studies that, when dealing with renovascular hypertension, the involved kidney (with marked renin secretion) showed renin release with much less reduction in arterial blood pressures than in normal individuals. More than half of the essential hypertensive patients studied were intermediate between these two groups and seemed to have an inappropriate release of renin into an already high pressure circulation.

If hypertensive patients reflect varying degrees of volume expansion and vasoconstriction, then the characterization of a hormonal profile should lead to a logical treatment program. In this consideration it is first necessary to consider the pharmacodynamics of the various anti-hypertensive drugs.[7]

Diuretics exert their anti-hypertensive effect by lowering total peripheral resistance by an unknown action which is thought possibly to be a direct action on arteriolar smooth muscle wall or by changing the electrolyte concentration or water content in the arteriolar wall. There is no major change in cardiac output, and the reduced extracellular fluid and plasma volume may contribute to its anti-hypertensive effect. It makes important contributions to prevent "refractoriness" of other drugs by offsetting their sodium retaining properties. Furosemide seems to have less of a hypertensive effect than thiazides.[8]

Propranolol has several possible mechanisms of action including decreasing renin secretion; reducing myocardial contractility, heart rate, and cardiac output; and by central nervous system effect by way of catecholaminergic neurons.[7] Its effect as a single agent is proportional to the plasma renin activity and to the degree of sympathetic tone and cardiac output (spontaneous or induced by other drugs). There is no orthostatic drop in the blood pressure as the sympathetic vasoconstrictor reflex is intact. Because of its reduction in heart rate and cardiac output, it must be used with caution in bradycardiac states and those patients in borderline heart failure.

Vasodilators. Apresoline is the only vasodilator currently available for long-term use and its effect is one of relaxation of arteriolar smooth muscle. The long-term effect of apresoline is limited by: (a) reflex increase in sympathetic activity which increases the heart rate and cardiac output, these factors reducing the hypotensive effect by 50 per cent or more, (b) its use is associated with increased renin activity and (c) retention of sodium and water. (a) and (b) above can be prevented by concomitant propranolol therapy and (c) can be prevented by a concomitant diuretic use.

Guanethidine works as a sympathoplegic agent. It decreases arteriolar and venous tone, with peripheral vascular resistance and cardiac output able to be depressed only to the extent which they can be maintained by sympathetic stimulation. Sympathoplegia to a significant enough degree to control blood pressure is often associated with significant side effects.

Reserpine acts primarily by decreasing peripheral

vascular resistance. There is diminution of the sympathetic stimulation of the blood vessels and heart due to depletion of norepinephrine stores in the sympathetic nerve endings and to action on the hypothalamus and vasomotor center. Maximum blood pressure lowering potential is limited to the contribution of sympathetic stimulation to the maintenance of arterial pressure, with the depressive effect of the drug often not allowing it for long-term administration of doses that produce high grade sympathoplegia. Usual daily doses of .25 mg usually have a hypotensive effect rarely exceeding 10 mm Hg.[7]

Methyldopa decreases peripheral arteriolar resistance and seems to exert most of its action by means of a central nervous system effect. It produces a false but efficient neurotransmitter which makes it unlikely that false neurotransmission accounts for its anti-hypertensive effect. It decreases plasma renin activity and over long periods causes expansion of plasma and extracellular volume and thereby loses some of its antihypertensive effectiveness, unless diuretics are concomitantly given to prevent this fluid retention.

The selection of the preferred drug therapy based on the principal pressor factors is summarized in Table I.

For essential hypertension with the usual features of an increased peripheral resistance but normal cardiac output, normal plasma volume and normal renin activity the use of a diuretic to lower peripheral resistance and to potentiate the action of other drugs, if they are necessary, seems logical. Predictable effects of this would be that the lowered plasma volume may increase the plasma renin activity and a diuretic alone may not control the hypertension. Additional drugs, if needed, would seem to be propranolol, as a second choice, to lower the plasma renin activity, and a vasodilator, as a third choice if needed. The stage should be set for maximum effectiveness of the vasodilator drug with propranolol and diuretics already in use. An alternative approach for a second drug would be the addition of methyldopa to the diuretic therapy to reduce plasma renin activity and decrease sympathetic stimulation of the heart and blood vessels or perhaps guanethadine, if the above are not tolerated for one reason or another.

For accelerated hypertension, which is characterized by marked and progressive increases in total peripheral resistance, blood pressure can be immediately lowered by intravenous vasodilators but the effectiveness of the vasodilator decreases without concomitant diuretic therapy and the diuretic is also necessary to maintain renal function. Sympathetic nerve stimulation and increased renin secretion might be predictable effects of this program and the addition of propranolol would decrease the renin activ-

TABLE I

DRUG THERAPY OF HYPERTENSION BASED ON PRINCIPAL PRESSOR FACTORS

Type of Hypertension	*First Drug and Rationale*	*Predictable Effects*	*Additional Drugs and Rationale*
Essential hypertension: increased peripheral resistance, normal cardiac output, normal plasma volume, normal renin activity	1) Diuretics to lower peripheral resistance and to potentiate action of other drugs	Possibly increased plasma renin activity May not control	2) Propranolol to decrease PRA* 3) Vasodilator (stage set for maximum effectiveness) OR 2) Methyldopa to decrease renin and CNS effect
Accelerated hypertension: increased peripheral resistance	1) Vasodilator to decrease peripheral resistance 2) Diuretic to preserve effectiveness and protect renal function	Increased sympathetic nerve stimulation Increased renin activity	3) Propranolol to decrease renin and prevent sympathetic increase in heart rate and cardiac output
Essential hypertension with high cardiac output	1) Propranolol offsets	Possible compensatory increased peripheral resistance	2) Diuretic to decrease peripheral resistance
Essential hypertension with increased renin activity	1) Propranolol to inhibit renin	Possible compensatory increase in peripheral resistance	2) Vasodilator and 3) Diuretic if needed (see above for rationale)
Essential hypertension with low renin activity	1) Diuretic (spironolactone or thiazide) to lower volume	May have secondary increase in renin	2) Propranolol to lower secondary increase in renin

* PRA = plasma renin activity.

ity and prevent sympathetic increase in heart rate and cardiac output caused by the vasodilators and be a logical additional drug.

Essential hypertension with high cardiac output is often associated with a high sympathetic stimulation and with reduced plasma volume. Systolic blood pressure is often increased greater than diastolic and there is an increased heart rate and increased stroke volumes. Propranolol is the logical therapeutic choice with the addition of a diuretic if there is a compensatory increase in peripheral resistance.

Essential hypertension with increased renin activity often has a prompt reduction in plasma renin activity and blood pressure when treated with propranolol, but if it does not, addition to the vasodilator and diuretic (for the reasons listed above) would be appropriate.

Essential hypertension with low renin activity seems to respond not only to spironolactone but also to other diuretics (which are cheaper and have fewer side effects) and effectiveness seems to be due to diuretic effect rather than specific reversal of mineralocorticoid activity.

In summary, with an understanding of the pharmacodynamics of various drugs and with hormonal characterization of the type of mechanisms causing the hypertension, we can get away from a rigid sequence of drugs used in the same fashion for all hypertensives and can select a drug with a relatively specific antihypertensive effect depending on what processor mechanism is involved. Of equal importance to selecting the first drug is to use the same rationale for selecting the second and third drugs, based on predictable compensatory pressor effects brought on by the initial drug treatment. ★★★

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BATTY STORY

Vampire: a hemo goblin.

—*The American Legion Magazine*

Systolic Click-Murmur Syndrome

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The syndrome of the late systolic click-late systolic murmur is now well recognized and is associated with prolapse of one or more (usually posterior) leaflets of the mitral valve. These individuals have a high incidence of electrocardiographic abnormalities, arrhythmias and bizarre complaints. Recognition of individuals with this syndrome (usually women) is based on a high index of suspicion and careful auscultation. The authors discuss diagnosis and treatment in detail.

THE LATE SYSTOLIC click and/or late systolic murmur have been recognized for many years and have been considered to be of extracardiac origin and of no particular significance. In 1962 Humphries and McKusick[1] noted ST-T abnormalities in the inferior-diaphragmatic leads of the electrocardiogram in many of these patients. They considered the association to constitute a definite electrocardiographic-auscultatory syndrome and considered these findings innocent and of pericardial origin. Barlow, Bosman, and Pocock (1963) demonstrated that mild mitral regurgitation was a common finding in these individuals[2] and that the mitral abnormality was characterized by a protrusion or billowing of the posterior leaflet (see Figure 1) into the left atrium during systole. In individuals in whom this protrusion (billowing or prolapse) occurred, an extremely high incidence of bizarre complaints (chest pain, breathlessness, dizziness, syncope, palpitation and fatigue) was noted.[3, 4, 5] Ronan, Perloff and Harvey (1965)[6] demonstrated by intracardiac phonocardiography that the auscultatory findings were indeed of mitral origin. Barlow, in 1969,[7] noted an unusual frequency of post-exercise arrhythmias and reported two patients in whom sudden death occurred. In addition to the late systolic click-late systolic murmur, apical whoops, honks and other auscultatory phenomena represent variations of the syndrome.[8] This paper reports and discusses our experience with the late systolic click-late systolic murmur.

Twenty-eight patients (21 women and 7 men) were studied. Their age ranged from 15-75 years.

The patients were investigated with non-invasive graphic techniques (phonocardiography, apex cardiography and echocardiography) and exercise testing. In selected patients right and left heart catheterization with left ventricular and coronary angiography was done.

RESULTS

1. *Graphic Features.* The usual location for the click and/or murmur was at the apex or somewhat medially. On occasion the click could only be appreciated with the patient in the extreme left lateral decubitus position. All patients had either a mid-to-late systolic click(s) and murmur, a late systolic murmur or click(s) alone (see Figure 2). In two, a pansystolic murmur with late systolic crescendo accentuated by a mid-to-late systolic click was recorded. The clicks were frequently multiple. The response to amyl nitrite inhalation was observed in 12 patients. With the usual response the click(s) moved toward the first heart sound and the systolic murmur increased in intensity, often lengthened, and

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moved to early systole. Occasionally a murmur was not evident except after inhalation of amyl nitrite. A satisfactory apex cardiogram was obtained in 17 patients. Sixteen showed prominent systolic retraction which coincided with the click (see Figure 3). The apex cardiogram of one patient was normal at rest but demonstrated marked systolic retraction following the inhalation of amyl nitrite. Echocardiography was performed in 4 patients. In each, late systolic posterior movement (prolapse) of the posterior mitral leaflet was demonstrated.

II. *Clinical Features.* Chest pain was the most common symptom (20 patients) but was not necessarily severe enough to cause the patient to seek a physician. In several it was seriously considered to be angina pectoris by the referring physician. It was usually atypical for angina pectoris and was often described as a sticking, sharp or jabbing precordial or inframammary sensation only occasionally precipitated by exertion or emotion or relieved by rest or nitroglycerin. The discomfort frequently lasted for hours or even days. Associated shortness of breath and palpitation were common. In only three instances was chest pain induced with exercise testing.

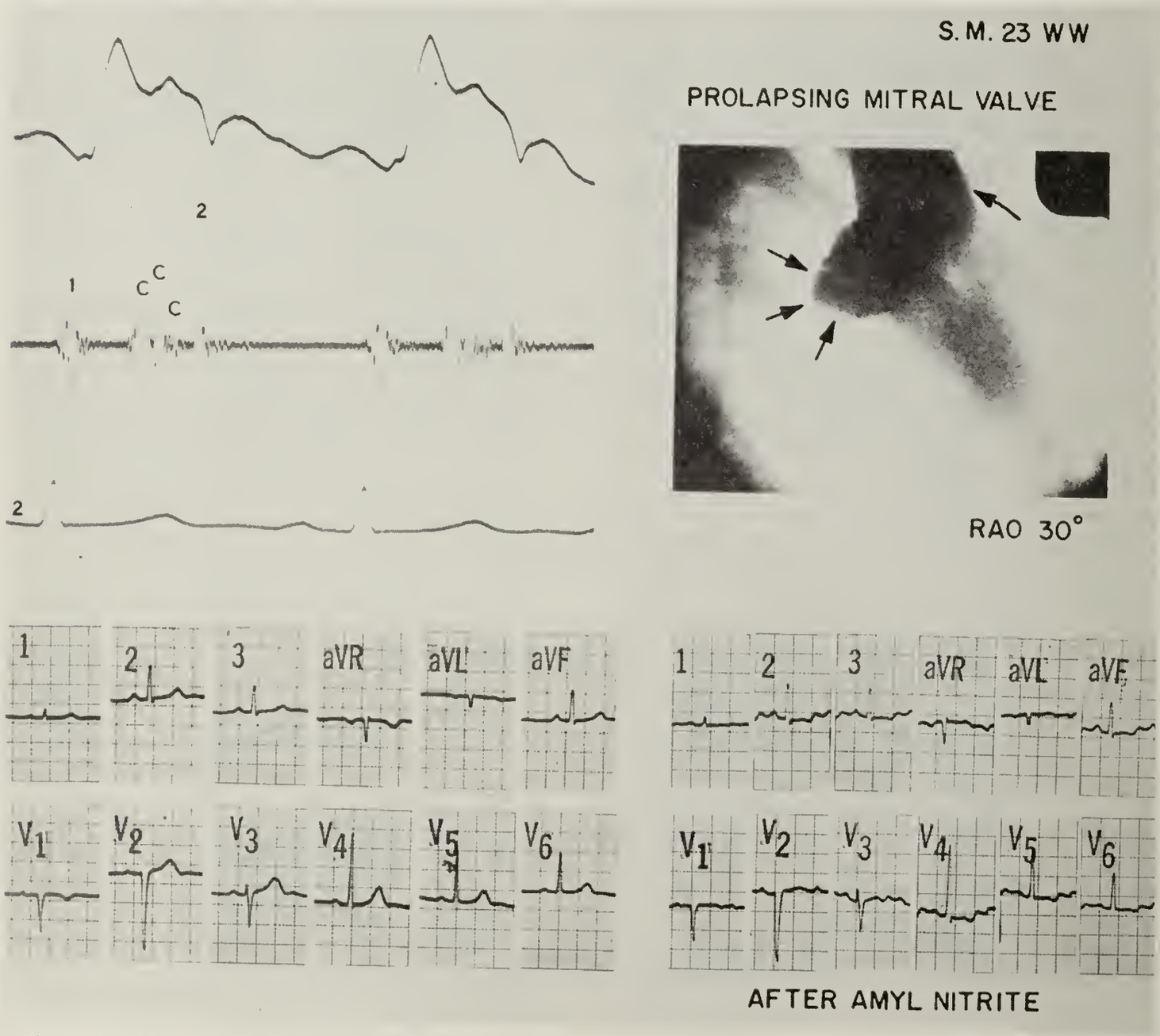


Figure 1. Upper right: Ventriculogram demonstrating marked "billowing" of posterior mitral leaflet (lower arrows). Anterior leaflet prolapse is also present (top arrow). Upper left: Phonocardiogram and carotid pulse recording demonstrating series of late systolic click(s) superimposed on late systolic murmur. Lower left: 12 lead ECG. Lower right: 12 lead ECG after inhalation of amyl nitrite, note "ischemic" ST-T leads, 2, 3, AVF, V4-6.

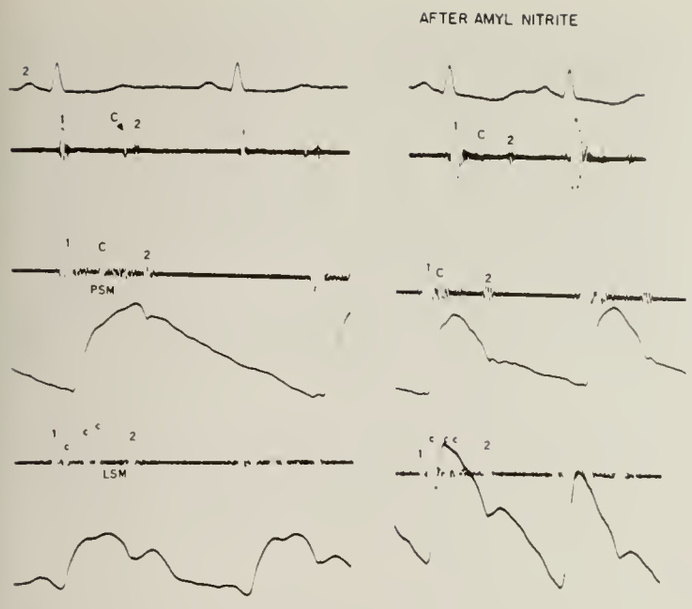


Figure 2. Illustrative phonocardiograms before and after amyl nitrite. Top: Late systolic click. After amyl nitrite click moves to mid systole and early systolic murmur appears. Center: Pansystolic murmur with late systolic crescendo and mid systolic click. After amyl nitrite click moves toward first heart sound and murmur shows early systolic accentuation. Bottom: Series of clicks with late systolic murmur. After amyl nitrite murmur becomes louder.

Four women were thought to have acute pericarditis (chest pain, "friction rub," and ECG abnormalities). Seven were referred for evaluation for unusual heart sounds, gallop or murmur. One patient was thought to have fixed splitting of the second heart sound possibly due to an atrial septal defect. This actually was a very late systolic click occurring just before the aortic component of S2. One woman was admitted to the psychiatric ward for evaluation of syncopal episodes which had been present for five years. She was experiencing episodes of paroxysmal atrial tachycardia at rates of 260 with a 1:1 ventricular response which resulted in syncope (see Figure 4). Another patient was referred because of an abnormal employment electrocardiogram (see Figure 5). Three patients were seen for arrhythmia and nine for chest pain that the patient's physician was seriously considering to be coronary artery disease.

III. *Electrocardiographic Features.* ST-T abnormalities in the inferior leads were observed in one-half of the patients. These were a low, diphasic, or negative T wave with flattening or depression of the ST segment in leads II, III, AVF (see Figure 6). Lateral precordial changes of a similar nature were also noted in a few patients. When the electrocardiogram was normal at rest it frequently was "abnormal" after amyl nitrite (see Figure 1). Arrhythmias at rest were noted in six patients, three had paroxysmal atrial tachycardia which was clearly the cause of recurrent syncope in one (see Figure 4). With exercise testing, seven demonstrated ventricular or atrial irritability or a combination of the two. Ectopy was usually noted during the immediate recovery period. As a group the level of exercise tolerance was much below that expected for the "normal" individual. Twenty-one patients were exercised on the treadmill. Eight demonstrated an "ischemic" ST-T response but only two of this group experienced chest discomfort. Seven of the 21 patients demonstrated ventricular or atrial ectopy or a combination of the two.

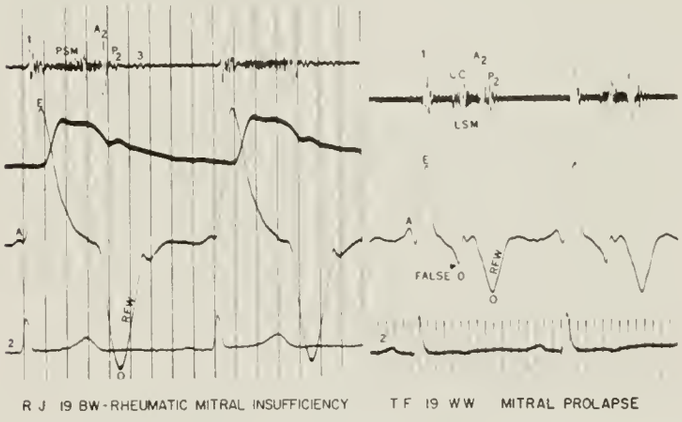


Figure 3. Right: Marked systolic retraction of apex cardiogram is present resulting in false 0 point. Systolic retraction corresponds to click which is probably a result of sudden checking of chordae tendineae. The true 0 point (opening of mitral valve) follows A2. Apex cardiogram of patient BW at left does not exhibit abnormal systolic retraction.

IV. *Cardiac Catheterization.* Cardiac catheterization with left ventricular angiography was performed in eight of these patients. All were found to have varying degrees of posterior mitral leaflet prolapse. One patient (see Figure 1) also demonstrated anterior leaflet billowing. Seven had coronary arteriography (normal in six, minor irregularities in one).

DISCUSSION

The late systolic click-late systolic murmur is not rare. However, until the past decade it has been infrequently recognized. Recent popularity of coronary arteriography has no doubt been a catalyst to clinical recognition. In the course of investigating individuals with chest pain (particularly women with abnormal electrocardiograms, arrhythmias, and "positive" exercise tests), the click is often found. We have been particularly impressed with the many ways of patient presentation. As might be expected when

dealing with a condition with such a spectrum of symptoms, auscultatory findings and electrocardiographic features, the mode of presentation was highly variable.

Unfortunately, an understanding of the pathophysiology has not kept pace with clinical awareness. The mechanism of the late systolic click-murmur is generally considered to be due to snapping (click) of the chordae tendineae coinciding with sudden checking of posterior movement of the mitral valve as it prolapses into the left atrium. Following the point of checking, slight mitral regurgitation may take place thereby producing the late systolic murmur. Usually the posterior mitral leaflet alone is involved but in some instances the anterior leaflet also prolapses. The etiology of the valve abnormality is not known. Because of the minor hemodynamic disturbances very few of these individuals have been examined by necropsy. In a few who have, a voluminous posterior mitral leaflet with thin, elongated chordae tendineae has been noted.[5] Because of the

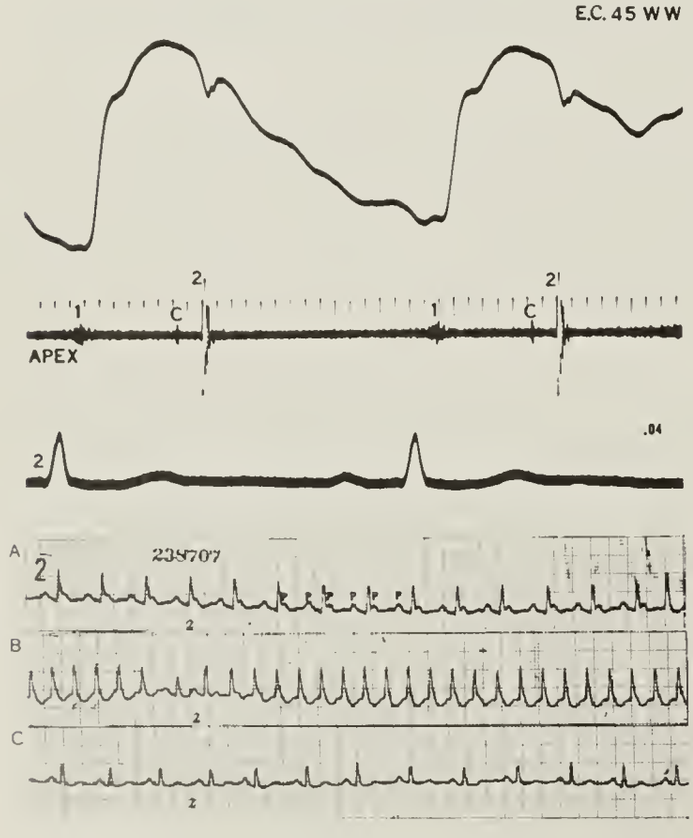


Figure 4. ECG recorded over period of 2-3 minutes. A. Paroxysmal atrial tachycardia at 260 minute with 2:1 A-V response. B. A few moments later 1:1 A-V response occurred and patient experienced syncopal episode. C. After spontaneous return to sinus mechanism. Phonocardiogram demonstrates late systolic click.

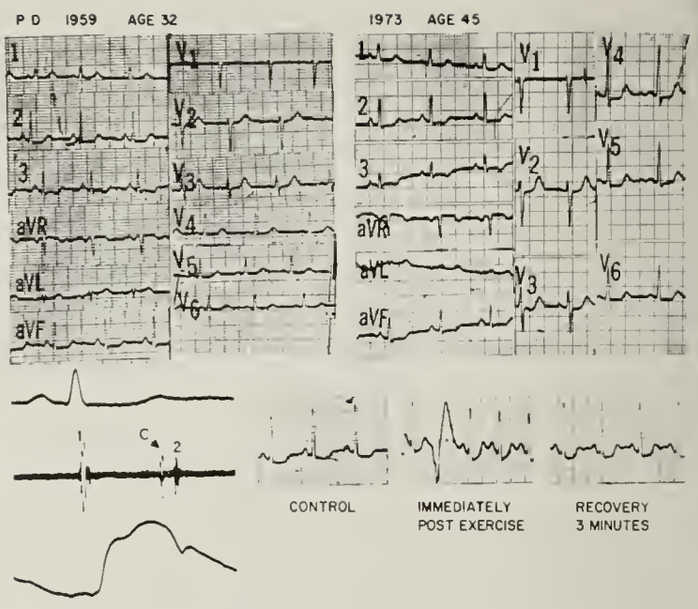


Figure 5. A 45-year-old woman referred for evaluation of abnormal employment ECG (right) note ST-T abnormalities 2, 3, AVF, showing little change from tracing at age 32. "Ischemic" ST response to exercise is present.

resemblance to valve pathology in patients with Marfan's syndrome it is possible that this represents a milder form of this disorder. Read[9] demonstrated myxomatous transformation of the mitral valve (the characteristic mitral lesion of Marfan's syndrome) in patients with severe mitral regurgitation who had functional complaints of breathlessness, chest pain, palpitation and arrhythmia. Because of the associated symptoms it has been suggested that this may be the common valve abnormality in patients with the late systolic click-murmur. However, most individuals do not have skeletal or ocular features of Marfan's syndrome but a tendency toward slenderness has been noted. Rheumatic fever, once considered an important cause, is not presently believed to be etiologically significant. Coronary artery disease with papillary muscle dysfunction has been suggested as a cause for the syndrome;[10] however, prolapse of mitral leaflet has yet to be clearly documented in papillary muscle dysfunction. Occurrence of the syndrome in patients with documented coronary artery disease can also be explained by chance association when one considers the commonplace occurrence of coronary artery disease. Since it is quite possible that the syndrome is secondary to several etiologies and mechanisms, trying to define a single etiology or mechanism is probably too restrictive.

The association of auscultatory findings to the resting or exercise electrocardiogram has never been satisfactorily explained. Why relatively insignificant

mitral valve dysfunction should alter ventricular repolarization is an enigma. It seems quite clear, however, that to consider the ST-T abnormalities "ischemic" in the classic sense is not proper. Except in the few instances of true angina pectoris, coronary arteriography invariably fails to demonstrate occlusive coronary disease.[11, 12, 13]

Although the coronary arteries are free of atheromatous lesions they frequently demonstrate unusual developmental patterns such as a "corkscrew" appearance and a short main coronary artery.[11] Additionally, several patterns of disordered left ventricular contraction have been described.[11] Our own experience would support the experience of others that the coronary arteries are free of atheromatous disease. Why these individuals should experience chest discomfort is obscure. Certainly there is no proof that the chest pain is in any way related to myocardial oxygen deprivation and the electrocardiographic changes should best be considered as an abnormality of ventricular repolarization of unknown cause.

A great deal of concern for the prognosis of these individuals has arisen following the report of Barlow and Pocock[7] of sudden death in two of their patients. They observed an unusual frequency of post-exercise induced arrhythmias and postulated that sudden death might be explained by a lethal arrhythmia such as ventricular fibrillation. Despite a relatively high frequency of minor exercise induced arrhythmias, sudden death is probably not common.[14, 15] The appearance of dizziness or syncope would seem at first glance to be related to the presence of an arrhythmia. However, this is difficult to prove. Eight of our patients experienced the symptoms but in only two could we demonstrate a rhythm disturbance to explain the symptoms (see Figure 4).

The reason for fatigue and breathlessness is also poorly explained. Many patients with neurocirculatory asthenia or the hyperventilation syndrome would no doubt fall into this group if examined carefully.

CONCLUSION

The diagnosis is made by a high index of suspicion (particularly the young woman with "angina pectoris" or an arrhythmia) and careful auscultation. Phonocardiographic demonstration is not necessary except in instances where the late systolic click is confused with a widely split second heart sound. The highly characteristic systolic retraction of the apex cardiogram (see Figure 3)[16] strongly supports the diagnosis of prolapsing posterior mitral leaflet. Echocardiography[17] is an excellent non-invasive method to demonstrate abnormal valve movement. Cardiac catheterization with left ventricular angiography is not necessary in the usual patient. (Coronary arteriography in the individual with chest pain that is atypical for angina pectoris is not necessary when typical auscultatory findings are present. However, in patients in whom angina pectoris seems likely then arteriography is justified.) A few patients with idiopathic hypertrophic subaortic stenosis (IHSS) in whom clicks were noted have been described. This particular condition might cause diagnostic difficulty particularly when syncope or dizziness are prominent symptoms. IHSS can usually be excluded by echocardiography.

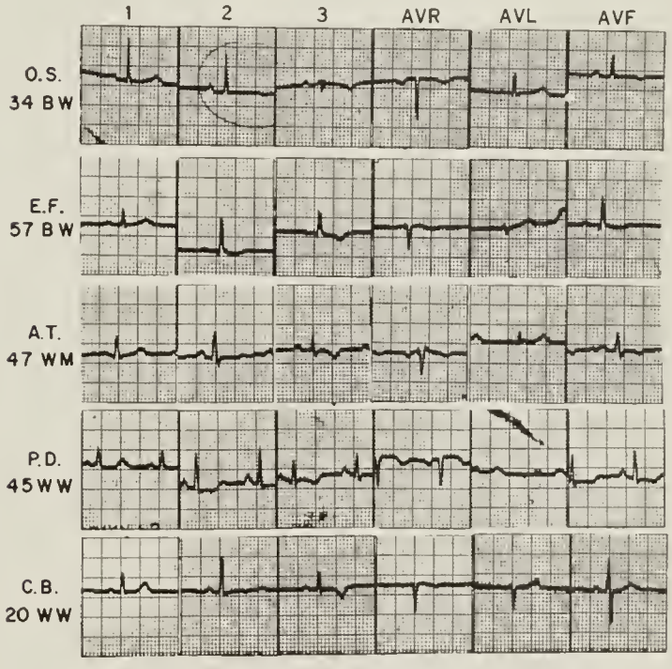


Figure 6. Electrocardiogram of 5 patients. Note similarity of ST-T abnormalities in leads 2, 3, AVF.

Treatment falls more into the supportive category with heavy emphasis on reassurance. Chest pain and palpitation may respond to propranolol.[7] Exercise electrocardiography should be performed in all patients to exclude an exercise related arrhythmia. In patients where dizziness, lightheadedness or syncope occurs, long-term ECG monitoring with a portable tape unit such as the Holter system is worthwhile. In view of the few reported instances of bacterial endocarditis, there is ample justification to employ prophylactic antibiotics at the time of dental manipulation.[18] The likelihood of progression to more severe mitral regurgitation does not appear great. However, such an occurrence has been documented and for

this reason it is probably wise to evaluate these individuals periodically with this in mind.

SUMMARY

The syndrome of the late systolic click-late systolic murmur is now well recognized and is associated with prolapse of one or more (usually posterior) leaflets of the mitral valve. These individuals have a high incidence of electrocardiographic abnormalities, arrhythmias and bizarre complaints. Recognition of individuals with this syndrome (usually women) is based on a high index of suspicion and careful auscultation. ★★★

2500 North State Street (39216)

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"I haven't seen you around lately," said the old lady.

"I've been at the university taking medicine," the student replied.

"Oh, I see. And are you better now?"

—*Mississippi Educational Advance*

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

Radiologic Seminar CXXXXIII: Esophageal Moniliasis

JOHN C. STEPAN, M.D.
Vicksburg, Mississippi

WITH THE increased availability and use of antimicrobial, cytotoxic, and anti-inflammatory corticosteroid agents patients with chronic debilitating disease survive longer than formally. The use of these therapeutic agents, especially in chronically ill patients, predisposes to a number of complications. One of these complications is an increased incidence of moniliasis.

Candida albicans is the causative microorganism of moniliasis. It is a common inhabitant of the gastrointestinal tract where it is usually nonpathogenic and produces no symptoms. Certain conditions may exist in the host which allow the organism to become pathogenic. Antibiotics are known to allow the overgrowth of normal intestinal flora and to cause disseminated fungus diseases. Steroids may lower the defense of the skin and mucous membranes against mycotic infections by their anti-inflammatory properties. Cytotoxic agents often produce a decrease in immunity of the host and predispose to infection by a normally nonpathogenic organism. Debilitating diseases such as diabetes mellitus, leukemia, and the collagen diseases may produce monilial infection even without the use of the above mentioned drugs. The most common sites for infection are the mouth, skin, vagina, and respiratory tract. Monilial infection of the esophagus is an unusual but clinically important form of the disease which should be diagnosed early in its course.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mercy Regional Medical Center—The Street Clinic, Vicksburg, Miss.





Figures 1 and 2 show a 39-year-old female who had received Tetracycline for 10 days. She experienced a relatively sudden onset of burning chest pain and dysphagia. Barium swallow reveals typical findings of moniliasis which were confirmed at esophagoscopy.

Clinically, esophageal moniliasis is characterized by a rather sudden onset of painful and difficult swallowing. The patient will often have a history of a debilitating disease, blood dyscrasia, or repeated infections. Usually these conditions will have been treated by anti-inflammatory, antibiotic, or cytotoxic drugs. The dysphagia is rapidly progressive and the patient may only be able to swallow liquids. Burning chest pain is also associated with the infection. There may be present oral moniliasis with the esophageal involvement being a direct extension of the oral infection.

The roentgenographic features of esophageal moniliasis are fairly characteristic and the diagnosis should be made with relative ease in patients with predisposing causes and the rapid onset of dysphagia. On barium swallow the involved portion of the esophagus shows irritability and spasm. The mucosa has a granular, cobblestone appearance due to a pseudomembranous lining consisting of the fungus organism and cellular debris. As the disease progresses inflammation and edema of the deeper layers produce superficial mucosal ulcerations. The esophageal outline then becomes markedly irregular and ragged and made up of numerous small indentations and protrusions. The longitudinal folds may still be discernible and the esophagus, though spastic, is still distensible. The entire length of the esophagus may be involved or the disease may be limited to a segment of the esophagus. If the disease is untreated the lesion progresses and there is complete loss of the normal mucosal pattern of the esophagus. The esophageal lumen becomes narrowed and the walls fixed.

Treatment of esophageal moniliasis consists of oral administration of Nystatin. Symptoms as well as radiographic signs rapidly improve following treatment and the esophagus may appear entirely normal radiographically within three or four days following treatment. The mucosal pattern will return to normal first followed by a relief of the irritability and spasm of the esophagus.

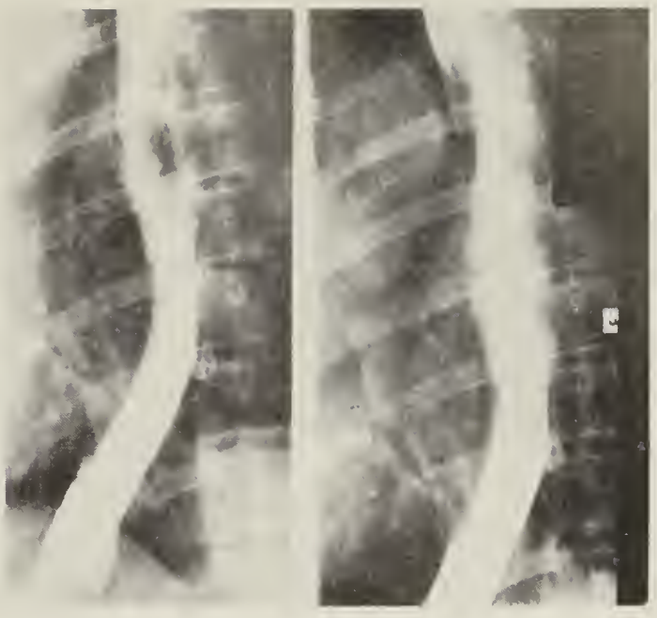


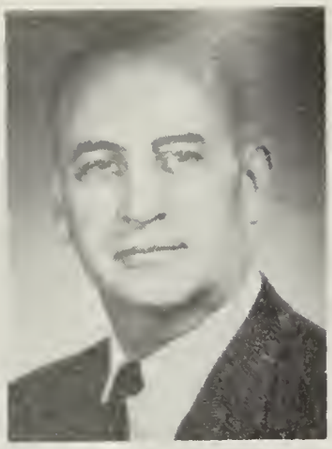
Figure 3 shows a barium swallow two weeks after treatment with Nystatin. The esophageal mucosa has returned to normal and all clinical symptoms had disappeared.

It is important that this disease be suspected and detected early in the course so that effective treatment might be instituted. Esophageal moniliasis is relatively innocuous and the symptoms are relieved if proper treatment is instituted early. However, if undetected it is a progressive disease and may contribute to the patient's death if not recognized. ★★★

The Street Clinic (39180)

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The President Speaking

Emergency Medical Service

J. T. DAVIS, M.D.
Corinth, Mississippi

EMERGENCY medical service to the American people continues to constitute one of the nation's largest unsolved health problems and the medical profession must face the challenge. We must realize that the greatest hazard to the life of the average citizen of this country is not fire in the home, nor crime in the street, but the inability of our present emergency medical system to reach those in immediate need of emergency medical care when the need is crucial and critical.

Accidental injury and acute illness generate a staggering demand on ambulance and rescue services, health personnel, physicians and hospitals, far greater than their level of capability to deliver. Each year more than 52 million persons in the United States are accidentally injured of whom more than 110,000 die. Many of these die before emergency medical help can reach them. Of the 670,000 deaths in 1973 attributed to coronary artery disease, 50 to 60 percent died before the patient reached the hospital.

In recent years, since the publication of the "White Paper" on the status of Emergency Medical Services in the nation in 1966, there has been increasing activity on the local, state, and federal level to improve these services. The Highway Safety Act passed by Congress in 1966 addressed itself specifically to performance standards of driver education, traffic records, motor vehicle inspection and the establishing of an ambulance service in each state. The 93rd Congress, noting the immediate needs of establishing or improving local and regional emergency medical services, appropriated 30 million dollars for the fiscal year 1974. This bill particularly emphasizes the importance of well equipped ambulances and adequately trained emergency medical personnel. After three years of effort on the part of concerned individuals working with the Mississippi Legislature, an enabling act was passed during the 1974 session to meet the performance standards of the Highway Safety Act of 1966.

This act of the Mississippi Legislature has given considerable impetus and support to the efforts of the Trauma Committee of the Mississippi Chapter of the American College of Surgeons, which pioneered the move toward better Emergency Medical Service in Mississippi and assumed the responsibility of coordinating a program to train emergency medical technicians and to establish standards for ambulances and emergency equipment. This is a mammouth task and can be accomplished only with the cooperation of the medical staff of each hospital, lending a hand in helping to coordinate the program.

(Please turn to page 411)

JOURNAL OF THE
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SEPTEMBER 1974

EDITORIALS

Ecology

In an address before the Economic and Social Council of the United Nations in 1965, Adlai E. Stevenson said, "We travel together, passengers on a little space ship, dependent on its vulnerable supplies of air and soil, all committed for our safety to its security and peace, preserved from annihilation only by the care, the work, and I will say the love, we give our fragile craft." This address is only one of many signaling the dangerous imbalances developing between man and his earthly environment.

We would all like to believe that these problems are limited to other regions, however, this is not the case. Environmental problems are present in our own state and those of us who have been fortunate enough to live in Mississippi for many years and have enjoyed its streams, clean air, pleasant climate, and other natural blessings should be more concerned than we are at the development of these imbalances. As physicians and leading members of our respective communities, we should all become active in preserving these things by acting and speaking out against special interest groups with limited and self-serving goals. Over recent months there have been many news releases regarding further industrialization of our state. While realizing and acknowledging that growth is necessary, we should all do our part to see that it comes about in an orderly and concerned manner with firm assurances that our natural gifts and resources will not be used in such a way as to produce irreversible imbalances; thus preserving for future generations the streams, clean air, and pleasant climate we now enjoy. In a letter to the editor of *The Journal of the South Carolina Medical Association* regarding environmental problems, Dr. C. Warren Irvin, Jr., made the following statement: "The constantly growing population which seems to be a main concern of the Chamber of Commerce is evident to us all. Certainly the financial status of even the poorest of our citizens is better than it was for many years, but I am concerned that his way of life is better, and I am certain that his children's way of life will never approach that of previous generations unless some radical changes are made."

Even if we choose not to become involved politically and actively on a local or statewide basis in regard to these matters, as physicians we are still concerned with the physical and mental illnesses produced by such changes. The physical problems created by air and water pollution, widespread usage of pesticides, herbicides, or other organic chemicals, noise pollution, industrial waste, heavy metal poisoning, exposure to radioactive material, and the more recently acknowledged effects of electromagnetic radiation demand development of a medical awareness of these problems, a clinical alertness to their existence, and proper medical management of the resulting illness. Preventive medicine has long been one of the major objectives in our practice of the art and science of our profession. It, therefore, seems only natural that as physicians we should become involved, if for no other reason than to attempt to prevent such illnesses in our population.

Dr. Rene Dubois in a speech before the American Association for the Advancement of Science made the following statement: "Humanizing the earth thus

implies much more than transforming the wilderness into agricultural lands, pleasure grounds, and healthy areas suitable for the growth of civilization. It also means preserving the kind of wilderness where man can experience mysteries transcending his daily life, and also recapture direct awareness of the cosmic forces from which he emerged." Let's all become active in preserving what we have and assuring ourselves, our children, and future generations not only a clean environment, but an environment with all of the pleasures we have previously enjoyed and an environment with some wilderness where all of us can experience the mysteries pervading our daily life.

MYRON W. LOCKEY, M.D.
Associate Editor
Jackson, Miss.

The American College of Physicians

From within and without the medical profession, the physician is pressured to have an updated knowledge base and to document proper utilization of this knowledge. It is indeed a cliché to say that proliferation of new medical information requires each of us to become a perpetual student. Few physicians can afford to spend more than a week or two annually away from practice in the pursuit of knowledge. To meet this need, there has been an avalanche of journals, books, throw-aways, movies, tapes (both video and aural), medical meetings, seminars, and lectures. Most physicians utilize all of these methods in varying degrees.

The American College of Physicians was organized in 1915 with the primary objective of "maintaining and advancing the highest possible standards in medical education, medical practice, and research." The present membership of 27,000 internists and allied specialists continues to pursue this historic goal. The college pioneered the innovative Medical Knowledge Self Assessment Program which is available to all physicians of whatever persuasion. The principal aim of the Self Assessment Program is to afford the physician an opportunity to evaluate his data base in the fields of internal medicine. It also provides an opportunity to each physician who so desires to check his score against that of the other 24,000 physicians voluntarily participating in the current Medical Knowledge Self Assessment Program III. The college is in the forefront of those favoring voluntary recertification with the first examination to be given this fall. The recertification examination will contain significant material from the 720 questions present in the Self Assessment Syllabus Program.

Among the innumerable activities of the college are regional meetings and postgraduate courses, each attracting approximately 5,000 physicians annually. This issue of the JOURNAL (and the October issue) contains papers presented at the Mississippi-Louisiana Regional Meeting of the American College of Physicians held in Biloxi, Feb. 15-16, 1974. The theme of this year's session was "New Thoughts on Old Diseases." The meeting alternates between Mississippi and Louisiana, and Shreveport will host the 1975 meeting, Jan. 24-25. All physicians are cordially invited to attend the scientific sessions.

The college is most appreciative to the Editor of the JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION for publishing these excellent papers. The *Journal of the Louisiana State Medical Association* published papers from the 1973 meeting in New Orleans, and hopefully this sets a precedent for future meetings to be published in the respective state medical journals.

GUY D. CAMPBELL, F.A.C.P.
Governor for Mississippi

A. SELDON MANN, F.A.C.P.
Governor for Louisiana



"Would you like to call in a computer of your choice for confirmation?"

Still, much remains to be done. The physician in each community because of his medical knowledge, concern for his patient, and his responsibility in delivering emergency medical care, should assume the leadership role in:

1. Educating the public to the needs of emergency medical service
2. Establishing adequate ambulance services for his community
3. Assisting in training emergency medical technicians and other paramedical personnel
4. Upgrading emergency room services in the hospital

Just remember when you enter the highway, you travel at your own risk. Your efforts to help improve the emergency medical service in Mississippi and reduce the hazards of the road are additional insurance toward you and your family returning home safely.

★★★

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NEW MEMBERS

BUMGARDNER, JOE R., Starkville. Born Fordyce, Ark., Oct. 3, 1940; M.D., University of Arkansas School of Medicine, Little Rock, Ark., 1966; interned University Hospital and VA Hospital, Little Rock, Ark., one year; surgery residency, same, 1967-71; elected by Prairie Medical Society.

COOKE, MAXWELL CAMDEN, Hattiesburg. Born Mullens, W. Va., Sept. 27, 1938; M.D., Medical College of Virginia, Richmond, Va., 1964; interned Roanoke Memorial Hospital, Roanoke, Va., one year; radiology residency, same, 1967-68; ob-gyn residency, University Medical Center, Jackson, Miss., 1969-72; elected by South Mississippi Medical Society.

RUSSELL, WILLIAM F., IV, Jackson. Born Birmingham, Ala., Oct. 5, 1942; M.D., University of Alabama School of Medicine, Birmingham, Ala., 1969; interned Baptist Medical Center, Birmingham, Ala., one year; radiology residency, same, 1969-73; elected by Central Medical Society.

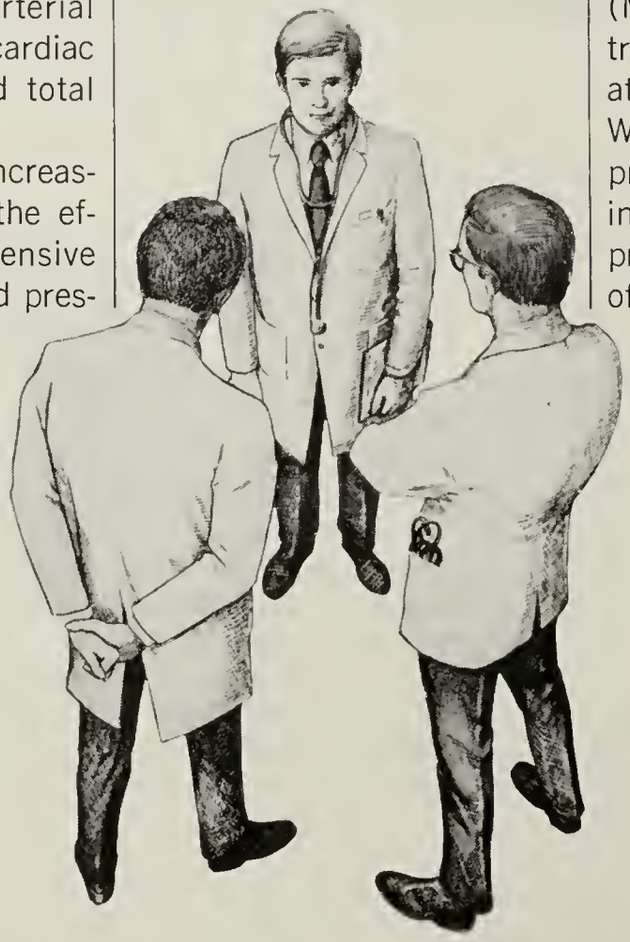
DEATHS

BROWN, ARTHUR E., Columbus. Born Dallas, Tex., Oct. 24, 1905. M.D., Northwestern University Medical School, Chicago, Ill., 1931; interned Hillman Hospital, Birmingham, Ala., one year; surgery residency, Wesley Memorial Hospital, Chicago, Ill., 1931-33; special study, Mayo Clinic, 1940; Past President, Northeast Mississippi Medical Society; Past Chairman of Board, Mississippi Cancer Society; Past President of MSMA, 1971-72; died July 29, 1974, age 68.

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

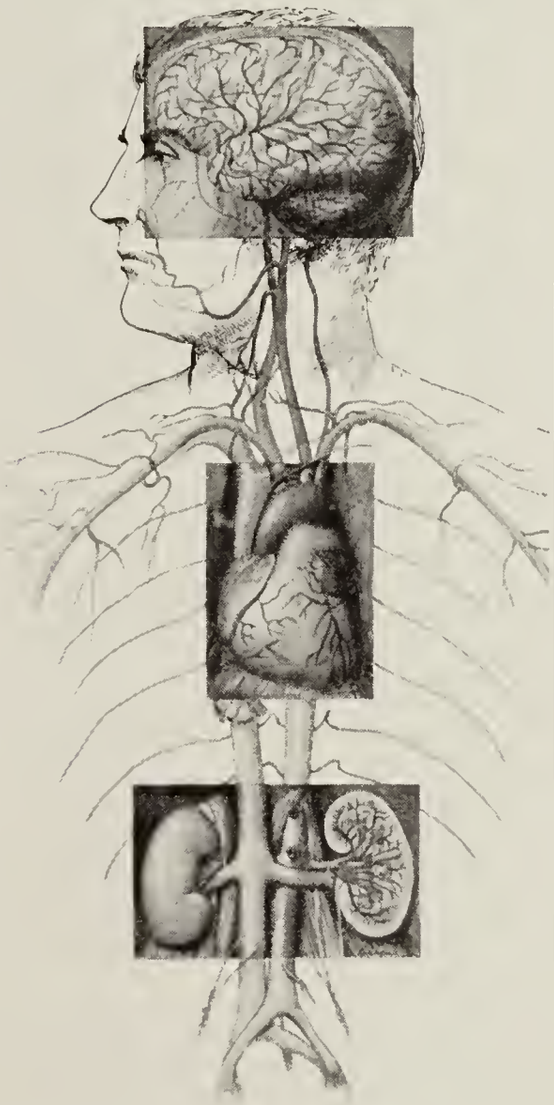
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD
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"Required Reading" For Your Hypertensive Patients



Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

Book Reviews

Treatment of Cardiac Emergencies. By Emanuel Goldberger, M.D. 355 pages with 231 illustrations. St. Louis: The C. V. Mosby Co., 1974. $14.00.

As the title states, this book is designed to assist the physician in preparation for cardiac emergencies which he may encounter in his daily practice. The title, however, is somewhat understated as there is not only a complete discussion of treatment of various emergencies that a physician might encounter but there are also chapters on longterm followup for pacemakers, the characteristics of pacemaker electrograms, and a very complete discussion of various drugs the physician has available.

The book itself is divided into three parts: Part I describes the various cardiac emergency syndromes and has chapters on cardiac arrest, cardiogenic shock, bradyarrhythmias and tachyarryhthmias. Part II is concerned with discussion of the equipment and apparatus used for cardiac emergencies and as such is useful in a book dealing with the treatment of cardiac emergencies. Part III describes drugs used in cardiac emergencies. This is one of the most useful parts of the book as drugs are discussed in terms of their pharmacology, absorption indications, contraindications, side effects and toxicity, and reaction with other drugs, etc. It had a discussion of some of the newer drugs such as bretyllium and dopamine which in the latter case has now become commercially available.

Some of the outstanding features of the book included a chapter on cardiopulmonary resuscitation which was very well discussed. There were some differences with the type of CPR recommended by the heart association in that the sequence of events as compared with the heart association recommendations varied, although I thought this difference was of a minor degree. I was personally glad to see that it was recommended in the book that electrical defibrillation be done even before an EKG is taken in the presence of cardiac arrest. I had never seen this advised before in print, and I think this is something that should be emphasized more often. As stated above, the discussion of the various drugs available was very complete and as such would be quite useful to a physician in the daily care of patients.

The only criticism of the book that I can make is that I think the book would benefit in its present format by condensing some of the chapters. For instance, rather than having a chapter on Acute Myocardial Infarctions and Complications following discussion of cardiogenic shock, I believe that these two could have been combined into one chapter and make the book more succinct as a reference book.

Overall, I think the book would be very useful to the practicing physician, and I can wholeheartedly recommend it.

James C. Hays, M.D.
Jackson, Miss.

Current Medical Diagnosis and Treatment. Edited by Marcus A. Krupp, M.D., and Milton J. Chatton, M.D. 1,018 pages. Los Altos, Calif.: Lange Medical Publications, 1974. $12.00.

In this day of medical practice with its heavy patient loads, a library is one of the most comforting aids we have. In addition to in-depth discussions in textbooks of medicines, we must have readily available information in compact form.

Current Medical Diagnosis and Treatment does fill this need. It has in its 1,018 pages, 31 chapters plus an appendix. The chapters cover the breadth of internal medicine with many charts and outlined disease discussions.

I reviewed this book by using it "in action," as I saw problems in my office or in the hospital. I graded each topic as good, fair, and poor for its completeness, but brevity. In general, most topics rated good, ranging from such diverse topics as organophosphate poisoning to multiple myeloma and myasthenia gravis.

This textbook is fun to scan; one discovers all sorts of interesting topics that are generally not found in one organized section of a general medical textbook. Such items as therapeutic diets and tables for antibiotic mixing incompatibilities are but a few of the useful topics. This book will serve as a useful desk reference to the general practitioner and internist.

A. Robert Dill, M.D.
Columbus, Miss.

PERSONALS

Rolando T. Abangan announces the opening of his office for the practice of neurosurgery at St. Joseph Medical Plaza in Meridian.

The Medical Center in Laurel announces the association of Robert R. Applewhite in the practice of general, vascular and thoracic surgery at 535 N. 5th Avenue.

Samuel D. Austin, Arthur W. Lindsey, and John T. Milam announce the association of John B. Milam in the practice of medicine and surgery at The Cleveland Clinic, Highway 8 East in Cleveland.

Ethridge and Godfrey, P.A. announce the association of William O. Bobo in the practice of plastic and reconstructive surgery at 508 Medical Arts Building, 1151 North State Street in Jackson.

Frank R. Briggs announces his association with the Jackson Surgical Group at 514-A East Woodrow Wilson Drive in Jackson.

Hugh P. Brown of Jackson announces the association of E. Frazier Ward for the practice of orthopaedic surgery at St. Dominic Office Building, Suite 508, 971 Lakeland Drive.

Judy F. Burroughs has associated with The Street Clinic in Vicksburg for the practice of pathology.

G. W. Byrne and W. K. Stewart of Gulfport announce the association of Donald A. Hopkins for the practice of general and thoracic and vascular surgery at 1213 Broad Avenue in Gulfport and 130 Fleitas Avenue in Pass Christian.

Joe A. Campbell, Jr., of Clarksdale announces the association of Ben B. Rader, Jr., for the general practice of medicine at 115 Sharkey Street.

Howard Cheek and George Smith of Jackson were guest speakers before the North Central Medical Society meeting held recently in Louisville. Dr. Cheek spoke on "Modern Trends in Diagnosis and Treatment of Serous Otitis Media" and Dr. Smith discussed "Modern Trends in Head and Neck Surgery."

John Coffey of Natchez was recently made the first Mississippi associate of LaLeche International, a league for the advancement of breast-feeding.

Robert A. Dale of Tupelo announces the relocation of his office from the Professional Building to 609 Brunson Drive.

Thomas C. Garrott announces the opening of his office for the practice of dermatology at 1404 Irish Hill Drive in Biloxi.

Ray N. Gregory announces the opening of his office for the practice of general surgery at Magnolia Doctors Plaza on Alcorn Drive in Corinth.

Robert J. Hargis of Jackson announces the association of Woodie L. Mason in the practice of urology at Suite 434, Hinds Professional Building.

Herbert H. Hicks of Natchez announces his return to general practice at 104 Trace Town.

Verner Holmes and Wendall Holmes of McComb and A. V. Beacham of Magnolia were honored by the Illinois Central Gulf Railroad with a dinner in honor of 25 years of service to the railroad.

Jack C. Hoover and Thomas R. Singley announce the association of Richard A. Nicholls in the practice of obstetrics and gynecology at Doctors Plaza in Pascagoula.

The Lockard-Wiener Ob-Gyn Clinic, P.A. announces the association of Calvin T. Hull in the practice of obstetrics and gynecology at 500-G East Woodrow Wilson Drive in Jackson.

John W. Hunter, Jr., has opened practice in the former Coursey Clinic in Raleigh.

Walter R. Jones, Jr., formerly of Hattiesburg, has associated with Richard Yelverton of Jackson for the practice of general and thoracic surgery at St. Dominic Medical Offices, 971 Lakeland Drive.

Jack C. Keen has joined the staff of the Hattiesburg Clinic as obstetrician-gynecologist.

George D. Ladner of Jackson announces the relocation of his offices to 1058 Riverside Plaza for the practice of psychiatry.

Albert H. Laws announces the opening of his office for diseases and surgery of the eyes at 816 Second Avenue North in Columbus.

Russell R. Lyle announces the opening of his practice in diseases of infants, children and adolescents at Medical Arts Clinic, 517 University Drive in Starkville.

Aida A. Malonzo announces the opening of her

office for the practice of obstetrics and gynecology at St. Joseph Medical Plaza in Meridian.

Paul H. Moore and Jeff A. Hodges of Singing River Radiology Group, P.A. announce the association of William Rowe Ehlert in the practice of radiology at 1365 Market Street in Pascagoula.

Edward R. North, Jr., of Jackson has been elected president of the Mississippi District Exchange Club.

Gerald M. Robertson has joined the Hattiesburg Psychiatric Group, P.A. at 405 South 28th Avenue in the Medical Arts Building for the practice of psychiatry.

John F. Russell of Gulfport has been selected to appear in the 1974 edition of *Who's Who in Mississippi.*

Stanley C. Russell of Jackson has been elevated to fellowship in the American Psychiatric Association.

S. A. Wade, Jr., and Jerry K. Lewis have associated with Rush Medical Group in Meridian. Dr. Wade is a urologist and Dr. Lewis is a family practitioner.

Richard B. Warren has associated with The Medical Clinic at 746 Manship Street in Jackson for the practice of internal medicine.

George E. Wilkerson announces the opening of his office at 1245 Broad Avenue in Gulfport for the practice of neuro-psychiatry.

John C. Williams has associated with The Street Clinic in Vicksburg for the practice of internal medicine.

POSTGRADUATE CALENDAR

Sept. 30-Oct. 4, 1974

Electrocardiography Intensive Course

University Medical Center, Jackson
Sept. 30, Oct. 1-4, 1974, beginning at 9:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
Thomas M. Blake, M.D., professor of medicine, the University of Mississippi School of Medicine

Selected for their immediate applicability, topics in this one-week course will be supplemented by use of electrocardiograms, slides, and other visual aids. The course will emphasize the interpretation of tracings as an important and integral part of the work. Participants will interpret electrocardiograms and join in conferences.

Oct. 28-Nov. 1, 1974

Neurology and Neurosurgery Intensive Course

University Medical Center, Jackson
Oct. 28-31, Nov. 1, 1974, beginning at 8:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
Robert C. Currier, M.D., professor of medicine, the University of Mississippi School of Medicine, and co-director of the stroke unit of the Mississippi Regional Medical Program
Armin Haerer, M.D., associate professor of medicine, the University of Mississippi School of Medicine

This course will include the management of adult and children's neurological disorders. Material will be presented in seminars, discussion groups and assigned readings and rounds on the wards and in the clinics. Rehabilitation techniques will be included.

Nov. 4-8, 1974

Hematology-Oncology Intensive Course

University Medical Center, Jackson
Nov. 4-8, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
Francis S. Morrison, M.D., associate professor of medicine and director of division of hematology, the University of Mississippi School of Medicine

Recent advances in oncology as well as the basics of diagnosis and therapy will be presented. Supportive management such as advances in component and problems of infection in immunosuppressed patients will be emphasized. Newer developments in hematology will also be covered.

POSTGRADUATE / Continued

Nov. 4-8, 1974

UROLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 4-8, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
W. Lamar Weems, M.D., associate professor of surgery and director of division of urology, the University of Mississippi School of Medicine

The emphasis of this course will be on practical urology as it relates to the nonurologist. The latest concepts and practices in common urologic diseases will be presented.

Nov. 11-15, 1974

CARDIOLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 11-15, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
James R. Galyean, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

The course will familiarize physicians with current concepts in bedside diagnosis of heart disease. Practical points in physical diagnosis and review of the various forms of heart disease will be covered using aids such as pulse tracings, phonocardiograms, electrocardiograms, x-rays, and hemodynamic data in illustration. Participants will round, watch cardiac catheterizations, and enter into team discussions on patient management. Reasons for suggesting or rejecting surgery will be discussed in detail. A cross section of cardiac diagnoses will be reviewed.

Nov. 18-22, 1974

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 18-22, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
John D. Bower, M.D., associate professor of medicine and director of the artificial kidney unit, the University of Mississippi School of Medicine

In this clinically oriented course, emphasis will be placed on reversible and treatable forms of kidney disease. The management of acute kidney failure and control of reversible features of chronic kidney disease will be presented in depth.

FUTURE CALENDAR

Tentatively scheduled are one-week intensive courses in radiology, pulmonary medicine, ENT, newborn, and pediatrics.

All intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, pharmaceutical firms, volunteer health agencies, and private donation. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged.

Medico-Legal Briefs

PROFESSIONS EXEMPT FROM FEDERAL ANTITRUST LAW

A minimum fee schedule issued by a county bar association did not violate federal antitrust laws, a federal appellate court in Virginia ruled. Antitrust laws do not apply to the "learned professions," the court said.

A couple who had contracted to purchase a home attempted to obtain an attorney to conduct a title examination at the lowest possible cost. They found that they could not retain an attorney for less than the minimum fee schedule published by the county bar association.

Claiming that the minimum fee schedule system was an attempt to restrain interstate commerce, the couple brought a class action against the county bar association and the state bar on behalf of themselves and other homeowners in the area.

The trial court found the state bar was not liable but that the county bar association was liable for treble damages under the federal antitrust law.

On appeal, the federal court considered the contentions of the state bar and the county bar association separately. The fees charged for legal services incident to the purchase of a home in the area were raised, fixed, and maintained at an artificial and noncompetitive level by the state bar's activities, the couple charged. They also questioned the validity of state bar opinions which stated that it was unethical

for an attorney to habitually charge less than the fee established.

The state bar had acted within the scope of its authority in publishing its minimum fee schedule, the federal appellate court said. It was not liable under federal antitrust law because of an earlier U. S. Supreme Court holding that the antitrust law did not apply to state action but only to individual action. The appellate court said that the action of the state bar met the three requirements for exemption.

First, the state bar's action was in the public interest. Fee schedules were just one of many factors that interrelated to provide the public with competent legal service. The fee schedules were aimed primarily at benefiting the public, and the fact that some benefits accrued to the attorneys being regulated did not frustrate the primary purpose, the appellate court said.

Secondly, the practice of law was under the active supervision of the highest court of Virginia. That court had delegated to the state bar some of its rule-making power. The second requirement, that of active supervision, was also fulfilled.

The third factor in the exemption test was whether the program received its authority from legislative command. The state legislature had created the machinery for regulating the legal profession, the court said. Since all three of the tests for the exemption were met, the state bar did not violate the federal antitrust laws.

As to the county bar association, the appellate court said that it clearly did not fall within the exemption because there was no active independent supervision of its activities. However, the legal profession was a "learned profession" and therefore not subject to antitrust laws, the appellate court said.

It was clear that the fee schedule and its enforcement acted as a substantial restraint on competition among attorneys in the county. Noting that there had been judicial recognition of the exclusion of "learned professions" from the scope of antitrust laws, the appellate court said that the practice of law was neither trade nor commerce. Citing two U. S. Supreme Court cases, the court said that learned professions were treated differently from other occupations.

Advertising and other forms of solicitation of business common to trade and commerce were criminal acts when used by lawyers. Attorneys had a professional duty to provide services at a reduced rate to those who cannot afford them. The restrictions of the antitrust laws were tailored for the business world, not for the noncommercial aspects of the learned professions, the appellate court said.

Learned professions are not above the law, the court said. The exemption is applied only where the attempted restraint is upon the profession itself.

In an earlier case a group of physicians who conspired to obstruct the interstate sale of health insurance were found to be in violation of the antitrust law because the sale of insurance was a trade or commerce. The occupation of the physicians was irrelevant, the court said.

However, conspiring to restrain the practice of another physician would not violate the antitrust law because the practice of medicine is neither trade nor commerce. In this case, the federal appellate court concluded that the fee schedule was part of the overall scheme to regulate the legal profession and was therefore immune from antitrust prosecution under the "learned profession" exemption.

Having concluded that the county bar association was exempt from the antitrust law, the court went on to say that there was no interstate commerce involved in the association's activities. The fee schedule allegedly restrained those engaged in financing and insuring homes by inflating a portion of the housing cost. To support jurisdiction over that claim involving a nonexempt activity, there must be some restraint on interstate commerce, the court said. The mere fact that out-of-state lenders and guarantors were involved did not support that jurisdiction. Any effect on interstate commerce was too remote, the court concluded.

Finally, the court said that it would not indulge in the business of policy-making in the antitrust area. If the antitrust laws were extended to cover attorneys, a lawyer might find himself in violation of the antitrust law if he used the fee schedule, but he would then be in violation of the state code of professional responsibility if he did not use the fee schedule. Either choice might result in punishment, and the law does not compel that harsh result.

For those reasons neither the state bar nor the county bar association violated the federal antitrust law, the court decided.

One dissenting judge disagreed with the majority's view that the legal profession was exempt from federal antitrust laws. He felt that the cases cited to support the exemption did not do so.—*Goldfarb v. Virginia State Bar*, Docket Nos. 73-1247, 73-1248 (C.A.4, May 8, 1974)

Editor's Note: Exclusion of learned professions from the federal antitrust law would include physicians as well as lawyers. The same is true of the exemption from state antitrust laws.

The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology



X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W.B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

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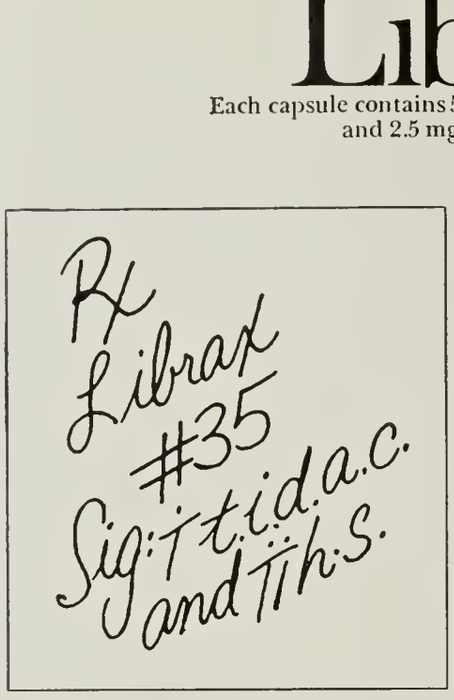
ROCHE

Please see summary of product information on following page.

An adjunct in anxiety-related upper functional G.I. disorders

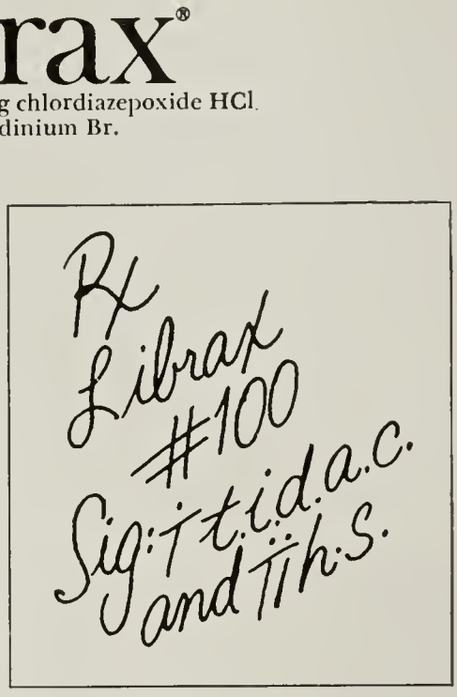
Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Initial therapy

The initial prescription allows evaluation of patient response to therapy.



Follow-up therapy

Follow-up therapy with a prescription for 2 to 3 weeks' medication usually helps maintain patient gains.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libid —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan™)—bottles of 100 and 500.

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LETTERS

SIRS: Tuberculosis patients who complete adequate chemotherapy should be considered cured and have no need for routine lifetime periodic recall. Prolonged followup of such patients diverts clinic resources from the crucial tasks of providing services to cases currently on chemotherapy.

Highest priority should be given to prompt and thorough treatment of newly diagnosed cases. Inactive cases diagnosed in previous years who have never had chemotherapy or who have had less than 18 months of two drug chemotherapy should receive preventive treatment.

If a patient has not responded well to drugs or has had an irregular course of treatment, efforts should be made to complete adequate therapy. Special treatment programs, such as directly administered ambulatory therapy, should be considered for such patients. Continuing periodic chest x-rays and bacteriologic exams should be considered only for persons in whom all attempts at therapy have failed. If such persons are in occupations where infectiousness may have serious consequences (such as some school and hospital personnel) they should be examined more than once a year or, if feasible, transferred to areas where there are minimal consequences to contacts if the person becomes infectious.

Persons who have responded well and completed the recommended course of therapy should be discharged with instructions to return only if they develop symptoms that could be caused by tuberculosis. Persons who have completed preventive therapy should be discharged with similar instructions.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

SBH Votes on Gulf Coast Waters

The Mississippi State Board of Health voted unanimously to adopt a resolution urging Gulf Coast officials to take appropriate action to inform the public of the potential health hazard that exists in the beachfront waters of the Mississippi Sound.

The 12-member-board at its quarterly meeting took the action after it was informed of a ruling by the Attorney General that the Board did not have the legal authority to require local coast officials to alert the public of the potential health hazard by posting or other appropriate measures.

State Health Officer Dr. Alton B. Cobb said that previous investigations by both the Mississippi Air and Water Pollution Control Commission and the State Board of Health have indicated that the waters do not consistently meet the standards for the body-contact recreation.

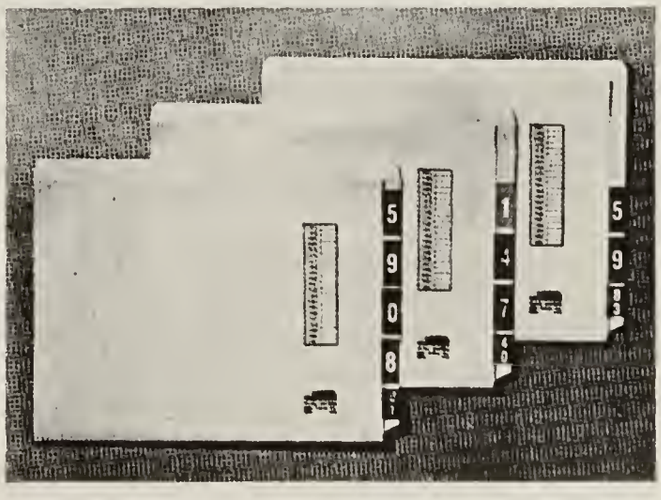
Dr. Cobb indicated that the Board was aware of the tremendous progress that local officials on the coast have made in attempting to remedy the situations that presently exist but the Board also expressed its concern that the residents and visitors on the coast be made aware of these conditions and their related potential public health hazards.

The Board further urged local officials to expedite the completion of their sewerage improvements to alleviate the current problem.

According to Dr. Cobb, the ruling from the Attorney General left the State Board of Health with the authority to investigate, advise, and make recommendations to local coast officials concerning the water conditions.

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1974 Southern Lung Conference Set for Biloxi

Physicians and other key volunteers from 13 state lung associations will convene at the 1974 Southern Lung Conference in Biloxi Sept. 11-13 at the Sheraton-Biloxi Hotel.

The three day meeting will be hosted by the Mississippi Lung Association, with Mrs. Mary Jane Green of Grenada, president of the Board of Directors, giving the welcoming address. Dr. Hawley Seiler of Florida, president of the Southern Lung Conference, will preside.

Speakers from Mississippi will include: Dr. T. D. "Bob" Lampton, coordinator, Mississippi Regional Medical Program; Dr. Wilfred Cole, past president of the Mississippi Thoracic Society; and Mrs. Martha Monaghan, Public Information Assistant, Mississippi Lung Association, all of Jackson.

The theme of the conference will be "People Involvement in the Prevention and Control of Lung Diseases." The agenda will include meetings on a wide variety of lung problems affecting the Southern regions of our nation, presented by physicians and lay volunteers.

The conference will be coordinated by Dr. E. C. Munnel of Oklahoma City, Program Topic Chairman; James E. Trussell, Jr., Executive Director of San Jacinto Lung Association, Houston, Tex.; and Judson M. Allred, Jr., Executive Director, Mississippi Lung Association.

The meeting will provide maximum benefits from the balance of physicians, volunteer workers and staff in attendance. The Annual Southern Conference Award will be given to a recipient contributing most to efforts toward better respiratory health in the southern states.

Ralph Morgan, Jr., Executive Director, Oklahoma Lung Association, is the President-elect of the Southern Conference with Ray Taylor of the Florida Lung Association, the new Secretary-Treasurer. Mr. Gerald R. Riso, the new Managing Director of the American Lung Association, will be a special guest speaker at the conference.

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
3. Measured tablet dose.
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An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

HYTUSS TABS

(GLYCERYL GUAIACOLATE 100mg.)





Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

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Mississippi Academy of Family Physicians Elects Officers and Holds Annual Meeting

Dr. Thomas J. Anderson of Laurel was inaugurated as president of the Mississippi Academy of Family Physicians at the 26th Annual Scientific Assembly held July 10-13 in Biloxi.

Dr. Richard T. Furr of Ocean Springs, former vice president, was elected president-elect. Immediate past president is Dr. William Bernard Hunt of Grenada.

Dr. Walter H. Rose of Indianola was elected vice president; Dr. Marion L. Sigrest of Yazoo City, secretary-treasurer; Dr. Joe E. Johnston of Mt. Olive, delegate; and Dr. James O. Stephens of Magee, alternate delegate. Dr. Charles R. Jenkins of Laurel will be serving the second year of his two-year term as delegate and Dr. A. T. Tatum of Petal will be serving his second year as alternate delegate.

Directors for five of the ten districts came up for re-election. Those elected were: Dr. Edgar D. Johnson of Hattiesburg—District 2; Dr. Charles N. Wright of Jackson—District 4; Dr. James W. Allison of Vicksburg—District 6; Dr. W. Arthur Brown of Mathiston—District 8; Dr. William B. Howard of Pontotoc—District 10. Other directors serving the second year of their two-year term are: Dr. Julian T. Janes of McComb, District 1; Dr. William M. Gillespie of Meridian, District 3; Dr. Walter H. Rose of Indianola, District 7; Dr. James O. Gilmore of Oxford, District 9.



New officers of the Mississippi Academy of Family Physicians are from left: Dr. Thomas J. Anderson of Laurel, president; Dr. Richard T. Furr of Ocean Springs, president-elect; Dr. Walter H. Rose of Indianola, vice president; and Dr. Marion L. Sigrest of Yazoo City, secretary-treasurer.



Three years of the MAFP presidency are shown from left: president-elect, Dr. Richard T. Furr; president, Dr. Thomas J. Anderson; and immediate past president, Dr. William B. Hunt of Grenada.

New officers were installed at the banquet on Friday evening by Dr. James G. Price of Brush, Colorado, President of the American Academy of Family Physicians.

Programs by guest lecturers on Mediastinoscopy, Acute Myocardial Infarction, Breast Surgery, Esophageal Hiatal Hernia, Lesions of the Eye, Treatment of Shock, Wound Healing, Hypertension and Facial Injury highlighted the meeting. Outstanding speakers were: Dr. James Caulie Gunnells of Duke University and Dr. Kenneth L. Mattox of the Texas Medical Center in Houston. Jackson physicians participating were: Drs. James P. Spell, James C. Hays,

Albert L. Meena, Kenneth N. Reed, J. George Smith, Wilfred Gillis, Hardy Woodbridge, Michael Jabaley, Michael Bryant, and Fred L. McMillan.



Representatives to the national academy elected at the meeting were Dr. Joe E. Johnston (at left) of Mt. Olive, delegate to AAFP, and Dr. James O. Stephens of Magee, alternate delegate.



Three of the newly elected directors are from left: Dr. Edgar D. Johnson of Hattiesburg, District II; Dr. W. Arthur Brown of Mathiston, District VIII; and Dr. James W. Allison of Vicksburg, District VI.

Dr. Edrie George Named Nursing School Dean

Dr. Edrie George is the new dean of the University of Mississippi School of Nursing at the Medical Center.

Dr. Norman C. Nelson, vice chancellor for health affairs, announced her appointment after approval by the Board of Trustees, Institutions of Higher Learning, at its July meeting.

The young nursing educator, a Greenwood native, assumed her new post Aug. 1. She succeeds Miss Christine L. Oglevee who retires this year after more than a quarter century as dean of the UMC nursing school.

Dr. George earned her B.S. degree in nursing at the Medical Center, her master's at the University of Colorado and the Ed.D. at the University of Mississippi.

Medical Center Announces New Faculty

Twenty-two new School of Medicine faculty will help welcome the school's largest freshman class at the University of Mississippi Medical Center this fall. Total medical student enrollment is expected to top 450, with first-year students accounting for 150 of that number.

At the associate professor level are Dr. W. Michael Bryant, plastic surgery, and Dr. James Weaver, pathology. Dr. Bryant got the M.D. degree at Johns Hopkins University, interned at the University of Michigan Medical Center, and did a residency at the University of Kentucky Medical Center. Dr. Weaver, who holds the M.D. from Northwestern University Medical School and the Ph.D. from Washington University Medical School, did internship at Passavant Memorial Hospital in Chicago and residency at Washington University Medical School at St. Louis.

Assistant professors are Dr. Wilton L. Marsalis and Dr. Macon Moore Weaver, anatomy; Dr. Karl Edmund Becker, Jr., and Dr. Fred Grover Davis, anesthesiology; Dr. John Barrett, Jr., and Dr. Charles L. Woodley, biochemistry; Dr. Alexander G. Cameron, family medicine; and Dr. Fred H. Ingram, Dr. Ralph Bethea, and Ms. Ruth D. Shiers, obstetrics-gynecology. Mrs. Shiers heads the nurse-midwifery education program.

New instructors at the Medical Center are Dr. William D. Davenport, anatomy; Dr. Jerry Griffin, and Dr. Graves Crawley Stubblefield, medicine; Ms. Marian Ellen Evans, and Ms. L. Ellen Miller, ob-gyn (nurse-midwifery); Ms. Jeannie Gouras, preventive medicine (biostatistics, research); Dr. Judith Becker, psychiatry and human behavior; Dr. Philip E. Cranston and Dr. Jane A. Sanders, radiology; and Ms. Karen Lynn Morere, surgery (otolaryngology).

Thirty-four different colleges and universities are represented in the new appointees' educational backgrounds.

Seven who got M.D. or Ph.D. degrees at the University of Mississippi Medical Center are Dr. Cranston, Dr. Stubblefield, Dr. Marsalis, Dr. M. M. Weaver, Dr. Griffin, Dr. Ingram, and Dr. Sanders.

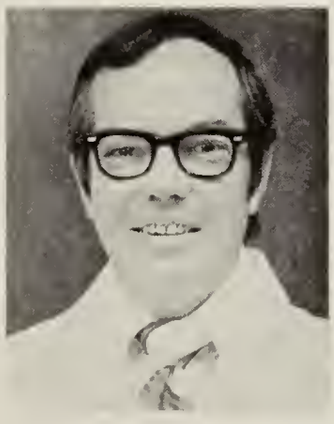
Johns Hopkins University alumni include Dr. Becker, Dr. Bryant, and Dr. Bethea.

Dr. Becker completed doctoral work at the University of Southern Mississippi; Dr. Davenport, Medical College of Georgia, Augusta; Dr. Davis, Hahnemann Medical College, Philadelphia, Pa.; Dr. Woodley, University of Nebraska, Lincoln, Neb.; Dr. Cameron, Dalhousie University, Halifax, Nova Scotia; and Dr. Barrett, University College, Galway, Ireland.

Dr. Robertson Heads UMC Continuing Education

Dr. Roland B. Robertson has been named director of a new division of continuing health professional education at the University of Mississippi Medical Center in Jackson.

He will also serve as an assistant dean in the Schools of Medicine, Dentistry, and Health Related Professions and as assistant professor of medicine.



Dr. Robertson

In announcing Dr. Robertson's appointment, Vice Chancellor Dr. Norman C. Nelson said the new division will coordinate ongoing and added continuing education programs for the entire health team.

Dr. Robertson said the division will continue the highly successful one-week intensive courses for physicians and other scheduled sessions and will expand the offering for physicians, nurses, dentists, and health related professionals.

A native Mississippian, Dr. Robertson has been an internist on the Jackson VA Hospital staff, a School of Medicine assistant dean for education at the VA Center, and as assistant professor of medicine.

He is a member of the Southeastern Regional Medical Program task force on education, hypertensive screening and treatment program, on the advisory committee of the Mississippi Heart Association hypertension screening program, and a past president of the Mississippi Thoracic Society.

Immunization Action Month Scheduled for October

As part of a continuing effort to reduce the incidence of childhood diseases and eliminate the threat of widespread epidemics, the Center for Disease Control has designated October 1974 as "Immunization Action Month." The goal of the program is to increase the number of children immunized against polio, measles, mumps, rubella, diphtheria, tetanus and pertussis.

Explaining the reason for the program, Dr. John J. Witte, director of the Immunization Division, Center for Disease Control, said that the percentage of young children immunized against these diseases has been declining at an alarming rate in recent years. As a result, diseases that were once well controlled, such as polio, measles and rubella, are becoming a problem once again.

"We still have children dying from these diseases each year," Dr. Witte said. "The real horror, however, is that not enough children are being immunized to assure that epidemics will not occur on a broad scale."

One of the main problems, Dr. Witte continued, is that many parents wait until their children approach school age before having them immunized. "This leaves the child unprotected during the first four or five years of his life, an age when some of the diseases are most serious and most likely to strike. Moreover, this means that if an epidemic occurs, it is most likely to spread quickly among children of this age group."

"The statistics are really pretty frightening," Dr. Witte added. "In 1963, 84.1 per cent of children between the ages of one and four were vaccinated against polio. Last year that figure was down to 60.4 per cent. That simply isn't enough to prevent epidemics. Anyone who remembers the polio epidemics of the 1950s, when thousands of children were permanently disabled, knows what that means."

Polio isn't the only problem. CDC statistics show that the percentage of young children immunized against measles has been dropping steadily. Last year, only 61.2 per cent of children in the one-to-four age group had been immunized.

"Some people still regard measles as a harmless disease and aren't too concerned about having their children immunized," Dr. Witte said. "But before vaccines were available, hundreds of children died each year from the disease. Encephalitis with permanent brain damage is a common complication of

the disease. Measles had been brought pretty well under control. In the past few years, however, we've begun to see outbreaks of the disease once again, and the possibility of an epidemic is becoming greater and greater."

The statistics for rubella, or German measles, are even worse, he added. In 1973, only 55.6 per cent of one-to-four-year-old children were immunized against the disease. "Ten years ago, we had a rubella epidemic that resulted in 30,000 miscarriages and caused serious disabilities in 20,000 babies. Then the vaccine was developed and, because of an intensive national immunization program, the epidemic predicted for 1970 or 1971 was prevented. But now we face the threat of an epidemic once again because not enough children are being immunized."

Family Medicine Residencies Discussed



During orientation for family medicine residents at the University of Mississippi Medical Center, five practicing physicians discussed the pros and cons of residencies in family medicine. After the panel discussion, first year resident Dr. Bill Jones of Jackson, second left, talked with the panelists, from left, Dr. Joe Miller, Jackson pediatrician; Dr. Tom Glasgow, Grenada family physician; Dr. Tom Stevens, Jackson internist; and Dr. John Murphy, Jackson family physician. "The biggest reason for a family medicine residency," the practitioners told the residents, "is to make as good a doctor of you in the residency program as we became after 15 years of lumps and bumps in learning to deal with a great variety of illnesses and administrative tasks."

NIH Announces Career Research Programs

Four special research career programs supported by the National Institutes of Health have been announced by Dr. Charles C. Edwards, HEW Assistant Secretary for Health.

Applications will be accepted by the National Institutes of Health from citizens or non-citizen nationals of the United States, or those who have been lawfully admitted to the United States for permanent residence. Candidates must be nominated for the proposed program by an appropriate non-federal public or private nonprofit institution located in the United States, its possessions or territories, and must have demonstrated considerable potential for developing the qualifications necessary to pursue careers in research and academic medicine. Awards will be made to the sponsoring institution on behalf of the candidate in one of the health professional areas listed by the following NIH awarding units.

The National Heart and Lung Institute is inviting national competition for *Pulmonary Academic Awards* which will have the dual purpose of improving the quality of pulmonary curricula and of fostering research and academic careers in the respiratory fields. Awards will be limited to one for each eligible school of medicine or osteopathy for a project period of up to five years with the possibility of renewal for an additional three years.

The institute hopes, through this program, to provide an impetus for schools that do not have an identifiable pulmonary curriculum to develop one; for schools that have a pulmonary curriculum that needs strengthening to improve it; and for schools that need someone to devote a major effort to the pulmonary curriculum, either to support a member of the staff or to recruit someone for the purpose.

The contact for this program is: Dr. Jay Moskowitz, (301) 496-7208, Division of Lung Diseases, National Heart and Lung Institute, Bethesda, Md. 20014.

The National Institute of Allergy and Infectious Diseases supports the *Allergic Diseases Academic Award,* which is intended to provide well-trained young medical scientists of demonstrated superior potential with an opportunity to develop the necessary qualifications for established academic positions in allergic diseases. At the same time it would provide an institution with a demonstrated need for the academic leadership required to initiate or augment essential investigations relating to allergic diseases.

Candidates should be under 40 years of age; hold a health professional degree in the clinical sciences (M.D., D.O., D.M.D., D.V.M., or equivalent); have 5 to 10 years of postdoctoral experience in areas relevant to allergic diseases, with broad training, and demonstrated competence in research, teaching, and clinical care. The award will provide support for a period of 5 years.

The contact for this program is: Dr. Luz A. Froehlich, (301) 496-7131, Assistant for Clinical Programs-Extramural Programs, National Institute of Allergy and Infectious Diseases, Bethesda, Md. 20014.

The National Institute of Arthritis, Metabolism, and Digestive Diseases is accepting applications for the *Clinical Investigator Award* in digestive diseases, nutrition, and diabetes. The awards are designed to foster independent research capability in young medical scientists—mainly those with between three and seven years of postdoctoral experience—who have demonstrated considerable promise as investigators during this period. They are available only to those holding health professional degrees (M.D., D.O., D.M.D., D.V.M., or equivalent). The award provides support for three years.

The contact for this program is: Dr. William Batchelor, (301) 496-7348, Clinical Investigator Awards-Extramural Programs, National Institute of Arthritis, Metabolism, and Digestive Diseases, Bethesda, Md. 20014.

The National Institute of Neurological Diseases and Stroke is continuing its program of *Teacher-Investigator Awards* in neurological and communicative disorders, e.g., neurology, neurosurgery, cerebrovascular disease, neuromuscular disease, neuropathology, otopathology, otolaryngology, audiology, and speech pathology. Awards are made for a 5-year period and provide support to candidates pursuing a research and teaching program which has been planned with the sponsor. Up to 10 new awards will be made annually.

The contact for this program is: Dr. Ray Summers, (301) 496-7725, Acting Chief, Special Programs Branch, Extramural Programs, National Institute of Neurological Diseases and Stroke, Bethesda, Md. 20014.

More detailed information and application materials may be obtained by contacting the appropriate participating institute. The deadline for receipt of applications is Oct. 1, 1974. Notification of final action will be made in March 1975.

MHI Effort Takes Shape

The House Ways and Means Committee has made public an initial draft for National Health Insurance. President Ford has given high priority to passage of NHI before this session of Congress ends and the House Ways and Means Committee will be the place to watch for any action in this regard.

The proposed bill in the words of Ways and Means chairman Wilbur Mills "takes the best from the many NHI proposals before the committee." From the Nixon administration's Comprehensive Health Insurance Plan and the AMA's Medicredit Bill come the proviso that the plan will be administered by private health insurance companies rather than a new federal agency. The companies would have to offer a benefit package specified and approved by the federal government.

From the Kennedy-Mills Comprehensive National Health Insurance Act comes the requirement that all Americans would have to be covered by the proposed NHI plan. Also that all institutions such as hospitals and nursing homes would be required to submit their annual operating budgets for approval in advance of payment by a state agency.

A broad range of benefits is proposed in the plan and no family would pay more than $1,000 a year for health care expenses. All medical bills of more than $6,000 a year would be covered in full with no deductibles or cost sharing.

In general, persons would be covered by the plan through employment with the employer picking up the largest part of the monthly premium. Persons not covered by health insurance through employment would be placed on the NHI plan through a "state health insurance corporation" with premiums paid in whole or part depending on the individual's financial status by state and federal funds.

One of the most dramatic provisions in the proposed plan relates to physician fees. Physicians who participated in the plan would be guaranteed full payment of fees proposed by the medical society or equivalent organization in a given geographic area. Physicians and their patients who decided not to accept the approved fees could not participate in the plan at all.

What's on your patient's face...

may be more important than his chief complaint

Patient P.T.* seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.



Patient P.T.* seen on 6/12/67, seven weeks after discontinuation of 5% FU cream. Reaction has subsided. Residual scarring not seen except that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J



The lesions on his face are solar/actinic— so-called "senile" keratoses... and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics. The typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.

Sequence of therapy— selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; this reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

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AAFP President Speaks at UMC



Dr. James G. Price, president of the American Academy of Family Physicians, left, discussed pending legislation that would affect the health care delivery world when he addressed first year family medicine residents and others at the University of Mississippi Medical Center. "Medicine traditionally has walked away from legislative matters," Dr. Price said, "but as an organization we feel we have to get off that kick."

UMC Appoints New Pharmacology Chairman

Dr. William O. Berndt has been appointed chairman of the Department of Pharmacology and Toxicology at the University Medical Center.

Vice Chancellor Dr. Norman C. Nelson announced the appointment following action of the Board of Trustees of Institutions of Higher Learning.

Dr. Berndt, whose appointment was effective July 1, succeeds the late Dr. William C. Holland. Formerly associate professor of pharmacology at Dartmouth Medical School, he is a native of St. Joseph, Missouri.

Dr. Berndt received the B.S. degree from Creighton University College of Pharmacy and the Ph.D. degree from State University of New York.

Primarily interested in the field of renal pharmacology, he is author of and contributor to more than 80 publications and abstracts.

He is a member of Sigma Xi, the American Association for Advancement of Science, and the International Society of Nephrology.

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MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 30-Dec. 4, 1974, Portland, Ore. Annual Convention, June 15-19, 1975, Atlantic City, N. J. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 68th Annual Scientific Meeting, Nov. 18-21, 1974, Atlanta. SMA, 2601 Highland Ave., Birmingham, Ala. 35205.

Tennessee Valley Medical Assembly, Annual Meeting, Sept. 30-Oct. 1, 1974, Chattanooga. Mrs. F. M. Richardson, Executive Secretary, 960 E. Third St., Chattanooga, Tenn. 37403.

Flying Physicians Association, 20th Annual Convention, Sept. 22-27, 1974, Broadwater Beach Hotel, Biloxi, Miss. Business Counsel, Albert Carriere, 801 Green Bay Road, Lake Bluff, Ill. 60044.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 9-12, 1975, Biloxi. Mrs. Alyce Palmore, Executive Secretary, P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 107th Annual Session, May 5-8, 1975, Biloxi. Charles L. Mathews, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, The Field Clinic, Centreville 39631, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Max Pharr, B6 Medical Arts Building, 1151 N. State St., Jackson 39201, Secretary.

Claiborne County Medical Society, First Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, P.O. Box 147, Port Gibson 39150, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday, April, and First Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, P.O. Box 128, Summer 38957, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, and November. J. H. Gaddy, 4502 15th St., Gulfport 39501, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando 38632, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian 39301, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez 39120, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. Robert B. Townes, 1196 Mound St., Grenada 38901, Secretary.

Northeast Mississippi Medical Society, First Thursday, March, June, September, and December. S. Jay McDuffie, Nettleton 38858, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford 38655, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune 39466, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. W. C. Welch, P.O. Box 5448, Mississippi State 39762, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Jeff Hodges, 1365 Market St., Pascagoula 39567, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb 39648, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie St., Hattiesburg 39401, Secretary.

West Mississippi Medical Society, Third Monday, January, March, May, September, October and November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, The Street Clinic, Vicksburg 39180, Secretary.

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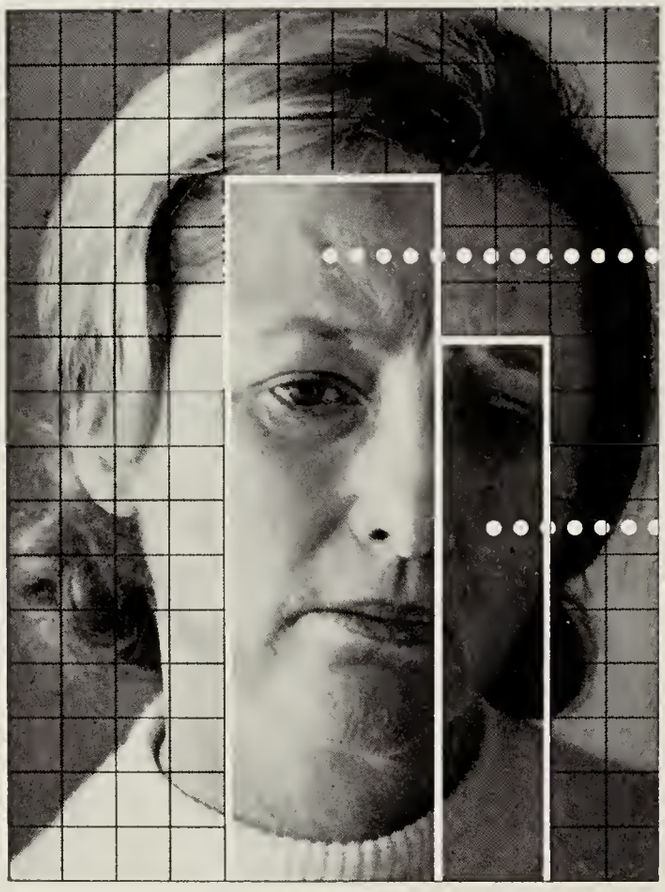
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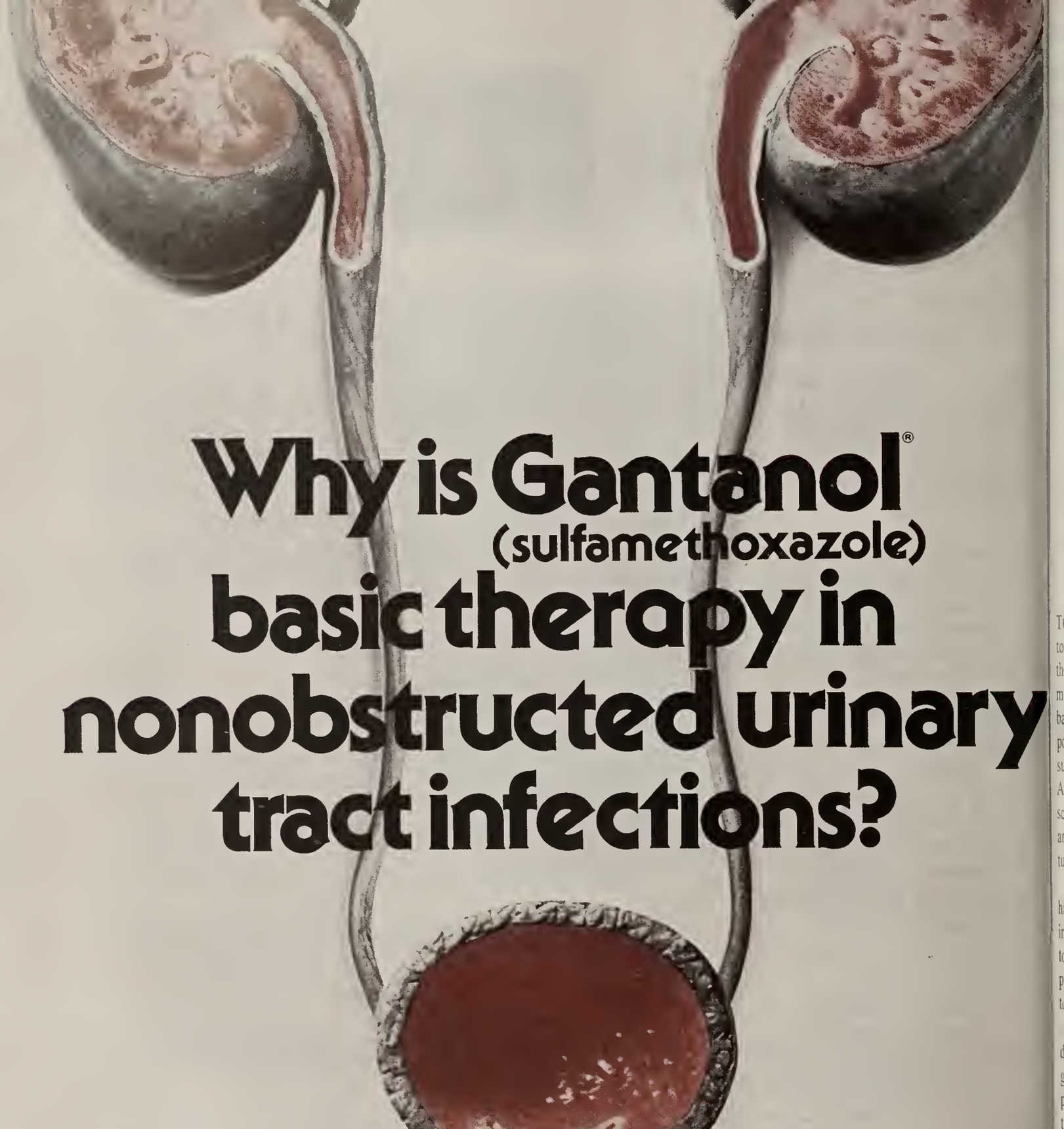
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The President Speaking **448** "Professional Responsibility"

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Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
October 1974, Vol. XV, No. 10

ORIGINAL PAPERS

Tuberculosis—New Thoughts on an Old Disease

HOWARD A. BUECHNER, M.D.
New Orleans, Louisiana

Tuberculosis is one of the oldest afflictions of man and has taken a heavy toll in death and disability throughout the ages. Improved treatment and economy have sharply reduced mortality and morbidity and have led to increased emphasis on prevention of this disease. Chemoprophylaxis, or preventive treatment using isoniazid (INH), has emerged as an important method of further reducing the incidence of active tuberculosis. However, the use of this tool has recently been impeded by what appears to be a rising incidence of INH induced hepatitis. A clearer perspective of this problem, an approach to its solution and a plea for continued widespread use of chemoprophylaxis are contained in this report.

TUBERCULOSIS is one of the oldest diseases known to man. Evidence of tuberculosis has been found in the bones of Neolithic man and in Egyptian mummies. The first recorded reference to the disease dates back to 1500 B.C. in the Indian literature. Hippocrates in 400 B.C. first named it phthsis (to consume—hence the still used name—consumption) and Aristotle recognized its contagiousness. Sylvius described the pathology of tuberculosis in 1650 A.D. and Koch discovered the cause of the disorder (the tubercle bacillus) in 1882.

At that time tuberculosis was reaping a grim harvest. In Budapest in 1876 the disease was causing 800 deaths per 100,000 population and in Boston in 1880 the death rate was 400 per 100,000 population, causing Oliver Wendell Holmes to refer to tuberculosis as "the white plague."

Following Koch's discovery, mankind's long and desperate struggle with this killer disease began to gain momentum. Forlanini introduced artificial pneumothorax treatment (1882); Trudeau opened the first sanatorium for the treatment of tuberculosis in the U. S. (1884); DeCerenville devised the thoracoplasty operation (1885); x-ray diagnosis began to attain general application (1920); streptomycin was introduced (1944) to be followed by para-aminosalicylic acid (PAS) (1949), isoniazid (INH) (1952) and a rapid succession of other drugs.

Under the impact of these weapons along with improved nutrition, sanitation, housing and a better standard of living, death rates from tuberculosis and the number of new cases each year began to decline. The death rate dropped from 200/100,000 in 1900 to below 3/100,000 at the present time. The new case rate showed a corresponding decrease. Victory over this ancient disease seemed close at hand and during the last decade the medical profession began to think not only in terms of control of tuber-

Presented at the Regional Meeting of the American College of Physicians, Biloxi, Feb. 16, 1974.
From the Department of Medicine, Louisiana State University Medical Center, New Orleans, La.

culosis but of attaining the ideal goal of "eradication" of the disease.

Two methods of reaching this theoretical goal were then at hand.

One consisted of the widespread use of a highly effective vaccine (BCG) which had been available for many years but had never achieved general acceptance in the U. S. Controversy still rages over the use, or lack of use, of this vaccine but it is not the purpose of this paper to enter the pros or cons of this argument. Rather, it is with the second method of eradicating tuberculosis that this presentation is primarily concerned.

This approach to the problem, referred to as chemoprophylaxis, or the preventive treatment of tuberculosis was conceived as early as 1953, based on experimental work in animals. By 1955 preliminary trials were being carried out on humans and by 1965 the concept was well established, having gradually gained favor with most chest physicians after a period of hesitancy over the revolutionary idea of treating patients who were not clinically ill and whose only manifestation of disease was a positive tuberculin skin test. The method is not really prophylactic but consists of identifying those individuals who had been infected by tubercle bacilli (positive skin reactors to tuberculin) at some time in the past and treating them with chemotherapy in order to prevent the development of clinical disease. Hence the concept is based on the treatment of infection at the earliest possible time rather than waiting for active disease to develop. This plan appeared to be sound, since it was demonstrated that approximately 75 per cent of all cases of clinical tuberculosis developed in individuals who had been previously infected (as evidenced by a positive tuberculin skin test) and that a year of treatment with INH was highly effective in preventing clinical tuberculosis in these individuals. The ideal plan would have consisted of identifying all individuals in the U. S. with a positive skin test and administering one year of treatment. All individuals with negative skin reactions would be retested at 6-12 month intervals and treatment would be given whenever a conversion from a negative to a positive skin test occurred.

Actually this approach was not practical since it required skin testing over 200 million people, treating approximately 40 million positive reactors (estimated in 1964) and retesting 160 million negative reactors at 6-12 month intervals.

Instead of applying the above principle on a comprehensive basis, careful risk factors were worked out beginning in about 1965 and those individuals most in danger of developing tuberculosis were categorized and selectively recommended for treatment (see Tables I, II, and III).

This selective method of chemoprophylaxis has been generally accepted in the U. S. and applied to the high risk groups in a somewhat random fashion, and has undoubtedly made an important contribution to a continued decrease in the incidence of active tuberculosis in our population. In support of this contention it is pointed out that the number of new cases of active tuberculosis in the U. S. has dropped from 54,000 in 1963 to an estimated 30,000 in 1973 while the new case rate per 100,000 population has declined from 28.7 in 1963 to an estimated 15 at present. Much of this decrease in the number of new cases of tuberculosis can probably be attributed to the influence of chemoprophylaxis since the rate of decline has accelerated to more than double since 1965 even though chemoprophylaxis has been applied in a random and still limited manner. In addition to what has already been achieved it is estimated that the more systematic and widespread use of chemoprophylaxis has the potential of preventing another 300,000 cases of active tuberculosis during the next 15 years, an accomplishment which would represent a long step toward the eradication of this disease.

TABLE I

RISK OF DEVELOPING ACTIVE TUBERCULOSIS

Negative tuberculin skin test:	
a. Close contacts of active cases	–1 : 200
b. All others	–1 : 50,000
Positive tuberculin skin test:	
a. Contacts of active cases	–1 : 30
b. Recent convertors	–1 : 30
c. Under 5 years of age	–1 : 30
d. Inactive disease—No prior chemotherapy	–1 : 120
(1) gastrectomy	–1 : 50
(2) unstable diabetes	–1 : 50
(3) pregnant	–1 : 50
(4) steroids	–1 : 50
e. 13 to 20 years of age	–1 : 150
*f. 5 to 12 years of age	–1 : 350
g. Males over age 45	–1 : 400
†h. All others	–1 : 1,400

* Individuals in this group will later enter group e and risk will increase.

† Males in this group will eventually enter group g and risk will increase. Risk factors for females are less clearly defined but also increase with advancing age.

TABLE II

PROPHYLACTIC TREATMENT MANDATORY

1. Positive reactors who are close contacts of active cases
2. All recent convertors—Any age
3. All positive reactors under age 20
4. All inactive cases who received no prior chemotherapy
 Retreatment indicated when:
 a) placed on steroids
 b) gastrectomy to be done
 c) diabetes discovered or becomes unstable
 d) pregnant
5. Silicotics with positive tuberculin skin test
6. Children with positive skin test who develop pertussis or measles—even if previously treated

TABLE III

PROPHYLACTIC TREATMENT RECOMMENDED

1. Negative reactors who are close contacts of active cases
2. *All* individuals (not in "mandatory" categories) whenever identified as having a positive Mantoux reaction of 10 mm or more.

However, an important drawback to the more liberal use of chemoprophylaxis has arisen in the last few years. The problem involves what appears to be an increasing incidence of sometimes lethal hepatitis caused by INH (the drug most widely used in chemoprophylaxis). Since its introduction in 1952 INH has been regarded as an agent of remarkably low toxicity and up until 1960 only 6 cases of INH induced hepatitis had been reported in the medical literature and only 2 deaths attributed to this drug had been reported prior to 1970. In 1970 however, an outbreak of tuberculosis occurred in Capitol Hill Complex employees in Washington, D. C. As a result of this incident a tuberculin testing program was instituted and 2,321 tuberculin positive individuals were given INH prophylaxis. Nineteen persons in this group developed hepatitis and two of these individuals died. These deaths were unusual in that hepatic disease was of late onset, occurring at about 8 months after starting therapy rather than in a 3 month period as is generally observed. In addition, one patient may have died of cirrhosis and the other of viral hepatitis. However, since they were both members of the Senate Press Gallery the incident received an unusual amount of publicity. To further compound the situation a similar INH prophylaxis program in Baltimore (in 1972) resulted in 30 cases of "liver disease" and 7 deaths in a group of 3,170. These incidents brought about a sharp reassessment of the use of INH for chemoprophylaxis and undoubtedly have caused some physicians to abandon its use. However, observations have led Public Health Officials to believe that the Washington and Baltimore experiences with INH prophylaxis were "unique" and do not reflect a true incidence of INH toxicity. In a review of programs in other cities there were 65 cases of hepatitis and only one death among 10,378 INH recipients, and in another review of 35,000 individuals receiving INH prophylaxis since mid 1950 there was evidence of subclinical liver involvement manifested by transient transaminase (SGOT) elevations in as many as 20 per cent of patients but there were only 14 cases of hepatitis and 5 deaths. The latter study reflects an incidence of hepatitis not dissimilar from that in the population at large not receiving INH. The use of INH chemoprophylaxis is therefore still recommended.

From the foregoing it may be concluded that:

(a) INH does cause hepatic dysfunction in 10 to 20 per cent of individuals. It is usually benign and of no clinical consequence. Evidence of hepatic dysfunction usually occurs within 90 days of beginning treatment and subsides even though the drug is continued.

(b) Occasional cases of clinical hepatitis will occur (about 40/100,000 at present) but this incidence can probably be significantly reduced by screening out patients with a past history of INH hypersensitivity or currently active liver disease and by close monitoring of patients with discontinuance of drug therapy if hepatic dysfunction persists or worsens or if signs or symptoms of liver disease appear. Laboratory tests of liver function (SGOT) can be used as an indication of the adverse effects of INH but these determinations are not really necessary or recommended[1] and patients can be simply observed for the onset of signs of liver disease or such symptoms as malaise, fatigue and anorexia. These symptoms almost always precede the onset of frank hepatitis which can be prevented if the patient is instructed to stop taking INH at the onset of these complaints. In virtually all cases liver dysfunction is reversible.

(c) Rarely death may occur from INH induced hepatitis (about 10-14/100,000 at present) but this incidence can probably be reduced to virtually 0 by careful monitoring of patients with prompt withdrawal of therapy under the conditions described above.

(d) Without question INH prophylaxis reduces the incidence of active tuberculosis in high risk individuals and can be expected to prevent approximately 300,000 cases in the next 15 years.

(e) For these reasons INH prophylaxis is still recommended for those individuals at high risk of developing active tuberculosis. The high risk group can be defined as all individuals with a positive tuberculin reaction of 10 mm or more since they are or will be in significant danger of developing active disease. This risk will increase with advancing age (see Table I). All individuals with negative tuberculin skin reactions who are close contacts of active cases should also be included in this group. However, at the discretion of the physician, the latter group may be managed with serial skin testing and treatment withheld as long as the skin reaction remains negative, or they may be started on therapy and retested 3 months after last contact with the active case. If the skin test remains negative preventive therapy may be discontinued.[1]

(f) Acceptable chemoprophylaxis for adults consists of the administration of INH, 300 mg daily (in one dose) for 12 months. Pyridoxine is given concomitantly in doses of 50 mg daily to prevent INH toxicity. Children should receive INH in doses of 10 mg per Kg daily (not to exceed 300 mg) for 18-24 months. To cover measles or pertussis children should be treated for 2 months. The concomitant administration of pyridoxine is not required in children.

(g) For those individuals who are placed on preventive treatment careful monthly monitoring is mandatory.

As a final new thought on the chemoprophylaxis of tuberculosis, it would seem appropriate to explore the potential of rifampin as a substitute for INH since this drug, while more expensive, is highly effective and appears to have a remarkably low order of toxicity.

There is also some evidence that the toxicity of INH varies according to its method of manufacture and research is needed to identify its least toxic form with subsequent assurance that only this form is made available for use by the medical profession.

Other new developments in the field of tuberculosis include:

(a) Discovery and identification of an increasing number of so-called "atypical" Mycobacteria which produce illnesses similar to tuberculosis but which differ from tuberculosis in that they are not transmissible from person to person.

(b) The development of new and highly effective drugs for the treatment of tuberculosis, including ethambutol, rifampin and capreomycin.

(c) The establishment of INH and rifampin (in combination) as the most effective regimen yet developed for the treatment of patients with less than far advanced disease. In addition to its high degree of effectiveness this drug combination has the advantage of oral administration in one dose per day.

(d) Recognition of the fact that tuberculosis can be treated effectively in non-hospitalized ambulatory patients; that patients on chemotherapy quickly become non-contagious and do not require isolation even though viable tubercle bacilli can be found in their sputum; that these patients can be safely discharged from hospital care and that intermittent (twice weekly) supervised treatment can be effectively employed in those patients who can not be relied upon to take their medicine on a daily basis.

All of these discoveries and innovations are finding their place in mankind's long struggle to rid itself of "the white plague." ★★★

1542 Tulane Avenue (70112)

REFERENCE

1. Farer, L. S.: Basics of RD—Preventive Treatment of Tuberculosis, Vol. 2, published by American Thoracic Society, 1940 Broadway, N. Y., N. Y. 10019.

A recent college graduate, a thoroughly modern young man, was asked if he was looking for work. He thought a moment, then replied, "Not necessarily, but I would like a job."

New Thoughts on an Old Disease—Diabetes Mellitus

JEROME R. RYAN, M.D.
New Orleans, Louisiana

The author relates the history of diabetes and treatments over the years. He emphasizes that the disease is still a problem since there are up to 10 million diabetics in the U. S. today, but with the artificial pancreas, islet cell transplantation, newer and different forms of therapy, problems for the diabetic patient can now be minimized greatly.

MAN HAS BEEN aware of diabetes mellitus for many years, with accounts of the symptoms of this disease dating back as far as 1500 B.C., although the first good clinical description was made a little less than 2,000 years ago. The complexion of diabetes, however, has changed with the contributions of many great physicians and investigators over the years. An appreciation of the pathophysiology of diabetes was greatly aided in the last century when Langerhans described the islet cells and when von Mering and Minkowski produced diabetes in animals by pancreatectomy. The greatest therapeutic advance came in this century just over 50 years ago with the extraction of insulin from the pancreas by Banting and Best and the subsequent amelioration of the diabetic syndrome by the administration of insulin. These and the many associated discoveries played major roles in increasing the understanding and improving the management of diabetes. The continuing evolution of new developments as they relate to any disease is not always appreciated, because they seem to occur quite slowly. One should consider some of the other changes that have occurred in this century. The life expectancy of a young diabetic 10 years of age in 1910 was such that the child would not be expected to live the year out. Today the chances are 999 out of 1000 that a 10-year-old diabetic will live at least one year. This represents a remarkable turnabout for a once dreaded disease. The youth of today have an entirely different attitude about diabetes. Diabetic teenagers now would rather have diabetes than an extra toe or acne.[1]

Before insulin was available there was little in the way of treatment that physicians could offer the diabetic patient. The mainstay of treatment was a very rigid diet, restricted especially in calories and carbohydrates. Figure 1 shows an actual dietary prescription for a young diabetic in 1914. The nutrients

DIET IN GRAMS

Carbohydrate	Protein	Fat	Alcohol
0	0	0	
0	0	0	
0	0	0	
5	3	0	
15	5	0	
25	5	0	

Figure 1

Presented at the Regional Meeting of the American College of Physicians, Biloxi, Feb. 16, 1974.
From the Department of Medicine, Therapeutics Section, Tulane University School of Medicine, New Orleans, La.

provided might suggest a form of punishment rather than treatment to us in the mid-1970s. Contrast this with the approach today and the advocacy of free diets and gourmet cooking for diabetics. However, this relative starvation diet did reduce the mortality rate for diabetes significantly. There has been renewed interest in dietary management as a tool in the prevention and treatment of stable maturity-onset diabetes in the obese patient. The effects on some patients are dramatic, as illustrated in Figure 2. Obesity greatly increases the mortality rate for diabetes and its treatment should be pursued vigorously.[2]

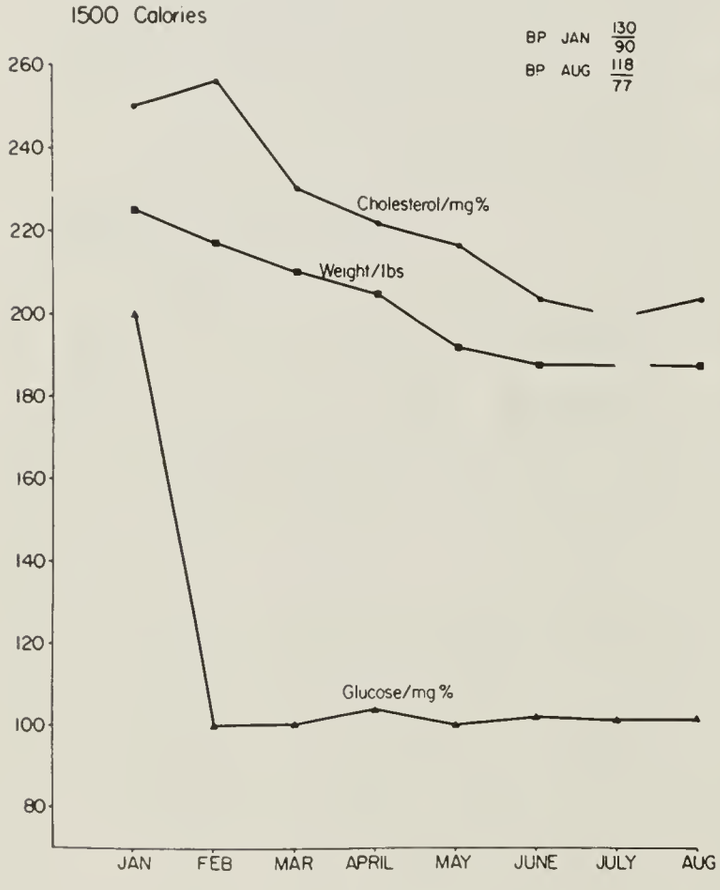


Figure 2

Insulin remains a mainstay of treatment for those insulin deficient patients. In the past year, a new, more highly purified form of insulin has been released in the U-100 strength. This insulin is commonly referred to as "single peak" insulin and will soon be available in U-40 and U-80 strengths. It is hoped that the switch to the metric system will simplify the measurement of insulin and minimize some of the dosing errors that have occurred in the past when double scaled U-40 and U-80 syringes have been used. Still 50 per cent of medical students do not know the number of units of U-80 insulin that is equivalent to any number of units of U-40 insulin. Since the "single peak" insulin is more highly purified, it has been found to be useful in the treatment of insulin atrophy.[3] This represents another area where there has been a complete turnaround. For years it was taught that sites of insulin injections should be rotated and that failure to do so would result in insulin atrophy. The "single peak" insulin can be injected directly into the sites of insulin atrophy and a gradual filling in of the atrophic area occurs. Figures 3 and 4 show a young diabetic before and four months after such treatment.



Figure 3

In 1922 an insulin order resembled that shown in Figure 5. There was very careful titration of single units of insulin, with the lot number being noted on the chart and the patients very closely observed. In the 1970's study of the artificial pancreas and pancreas transplantation are proceeding as sources of insulin based on the rapidly changing metabolic requirements of the insulin deficient patient. Soeldner and colleagues are in the process of evaluating a miniature glucose sensor, computer and insulin pump



Figure 4

that will respond to changes in blood glucose by the infusion of a concentrated form of insulin.[4] Perhaps before this, a glucose sensor will be perfected whereby fluctuations in serum glucose can be monitored by external monitoring systems.

In the past few years, important questions have been raised about the dangers of oral hypoglycemic agents, especially by the University Group Diabetes Program study, and the debate still continues. The University Group Diabetes Program study suggested that the oral hypoglycemic agents caused an increased cardiovascular mortality rate in those diabetics who took this form of medication.[5] However, when the study was analyzed it was learned that the placebo treated patients were considerably more healthy in terms of cardiovascular risk factors. One such analysis which considers the rank of the risk factors listed in Table I is shown in Table II.

TABLE I
RISK FACTORS

Age	Serum cholesterol
CVD—father	Cardiothoracic ratio
CVD—mother	History of digitalis use
GTT criteria	History of angina pectoris
Fasting blood sugar	ECG abnormality
Body weight	Fundus photo abnormalities
Blood pressure—diastolic	Arterial calcification
Serum creatinine	History of intermittent claudication

TABLE II

RISK FACTORS
Mean Rank

PLBO	*TOLB*	*ISTD*	*IVAR*	*PHEN*
2.187	3.432	2.968	2.875	2.906

Furthermore, other studies, such as that by Keen and Jarrett, do not confirm this increased mortality rate.[6] Efforts are continuing, at this point in time, to develop new oral agents, such an sulfamylureas, which chemically are somewhat different from the

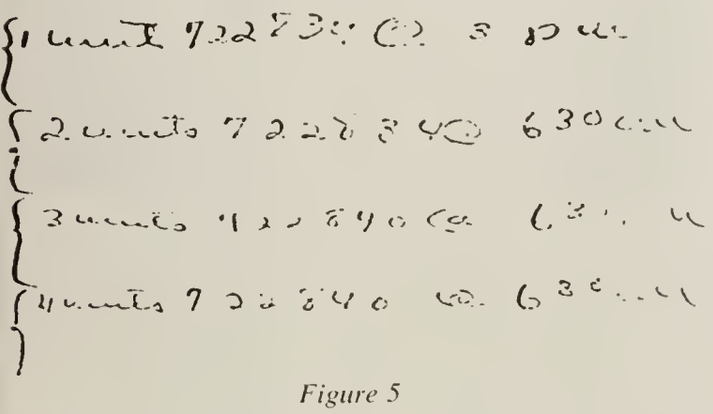


Figure 5

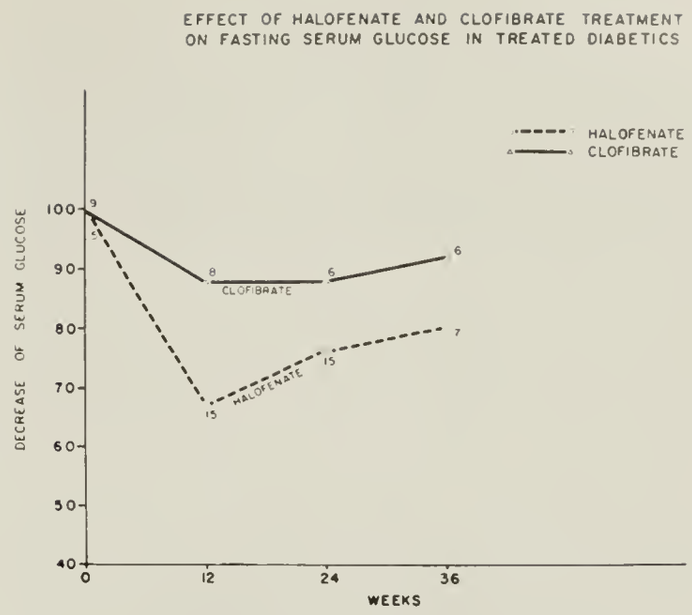


Figure 6

sulfonylureas. They are similar in that they cause a release of insulin from the islet cells of the diabetic patient in a graded fashion, which in turn causes a lowering of blood sugar when compared with placebo. These drugs have a very short half-life and theoretically might be drugs that could be taken immediately prior to a meal to hopefully normalize the islet cell response to eating in the maturity onset diabetic patient.

In the 1970s with the great degree of specialization that exists and the relatively large number of doctors that each patient is seeing, and drugs that patients are taking, the problem of drug interaction has to be considered. No longer can the physician be content to focus his attention on the single drug entity which treats the disease with which he is con-

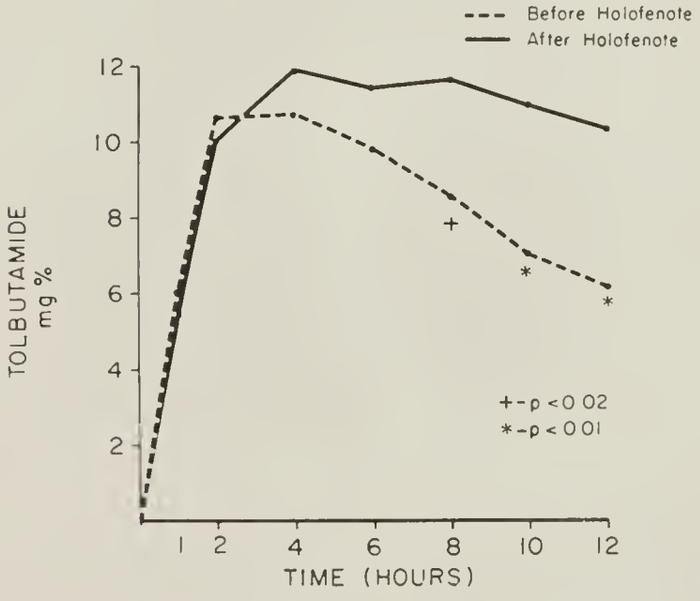


Figure 7

cerned. He must also be concerned about other drugs that the patient may be taking. As illustrated in Figure 6, a certain group of patients, concomitantly receiving oral hypoglycemic agents and antilipemic agents, showed a definite decrease in blood sugar. When this point was evaluated further it was learned that halofenate significantly influences the blood drug levels of tolbutamide when the two drugs are given concurrently (see Figure 7). This interaction is thought to represent displacement by competition for the same binding sites.

The problem of diabetes remains with us, and the magnitude of the problem, in many respects, appears greater than it did in the 1920s, with estimates of up to 10 million diabetics in the United States. But as in the 1920s, there is considerable hope. With the artificial pancreas, islet cell transplantation, newer and different forms of therapy, problems for the diabetic patient can be minimized considerably. Many of the problems of diabetes have been solved. To realize how many, one just has to look back, and not too far at that. ★★★

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A playboy was yatching among the Greek Isles when he fell overboard and injured his back. He was rushed to the nearest clinic, where the local doctor told him gravely: "Brace yourself, the prognosis is not good. You'll probably never work again."

The jet setter replied bravely: "All right, I can take it. What's the bad news?"

Radiologic Seminar CXXXXIV: Isotope Venography in Suspected Pulmonary Embolism

R. B. ELLISON, M.D.
Biloxi, Mississippi

INCREASED CLINICAL awareness regarding pulmonary emboli plus improved diagnostic procedures such as isotope lung scanning and pulmonary arteriography have shown pulmonary embolism to be much more frequent than was generally suspected as recently as 10 years ago. Pulmonary embolism has come to be recognized as not only the most common lung disease in patients in general hospitals[1] but also the cause of death most frequently diagnosed at autopsy.[2] The disease accounts for many deaths in the postoperative period, is the greatest single factor in mortality in childbirth and has a high incidence in patients with protracted medical illnesses.[3] Of perhaps even greater significance, pulmonary embolism has been found to be the most likely major lethal disease to be misdiagnosed.[2]

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Howard Memorial Hospital, Biloxi, Miss.



Figure 1. Portable chest films on this patient show no abnormality. Chest films obtained on these quite ill patients suspected of having a pulmonary embolus are frequently portable and often yield only gross diagnostic information.



Figures 2 and 3. The lung scan shows multiple areas of decreased perfusion, none of which are striking. Altered perfusion due to bullous pulmonary disease cannot be ruled out.

The source of most of these pulmonary emboli is no mystery, since autopsy studies have shown that 50 to 80 per cent of hospitalized patients have lower extremity venous thrombi, three-fourths of which are clinically asymptomatic.[4]

An unequivocal diagnosis of pulmonary embolism is often impossible to make, even when the most sophisticated diagnostic facilities and procedures are available. A sophisticated procedure such as pulmonary angiography, however, may not be generally available or utilized in community hospitals. In addition, pulmonary angiography is an invasive procedure and carries a significant hazard.

Rectilinear isotope scanning equipment is, in contrast, generally available in community hospitals and the lung scan is frequently of great help to the clinician who is faced with a diagnosis of possible pulmonary embolism. This is especially true if the lung scan shows a discrete zone of decreased or absent perfusion and the chest x-ray is negative. The lung scan may also be considered diagnostically definitive when the chest x-ray (for example) shows pneumonia and intrapleural fluid in one region of the chest while the scan shows decreased perfusion in that area plus one or more additional regions.

The wary clinician may still have reservations about the certainty of a pulmonary embolus having occurred, however, since chronic obstructive pulmonary disease or isolated emphysematous bullae can sometimes be extremely difficult to detect on plain chest films and yet present as areas of decreased perfusion on the lung scan.

In any instance when the diagnosis of pulmonary embolism is suspected, demonstration of foci of lower extremity venous thrombotic disease lends additional circumstantial evidence suggesting pulmonary embolism. This is especially true when iliofemoral thromboses can be demonstrated since it has been shown that those thrombi above the calf are by far the most likely to embolize.[3]

The technically simple isotope venogram (radionuclide venography) can often be of special value when performed in conjunction with the lung scan. With the patient supine and otherwise prepared for the lung scan, tourniquets are applied to each leg approximately three to five inches above the ankle and half of the Technetium 99M labeled Albumin Microsphere dose is injected into a dorsalis pedis vein of each foot. The injection of 1.0 to 1.5 millicuries of the material into each foot may be accomplished via a 21 to 25 guage butterfly needle with subsequent flushing of the tubing accomplished with 4 to 5 cc. of injectable saline.

The lung scan is next performed in the usual fashion and is followed by a "survey" scan of both lower extremities by moving the detector slowly over both lower extremities and the pelvis. If no more than background activity is detected, deep venous thrombosis in the legs can be relatively safely excluded. If one or more "hot spots" are detectable, a simple rectilinear scan of the legs will record the extent of the venous disease. The reason for accumulation of the Microspheres at the site of a thrombosis or thrombophlebitis is not known with certainty. An electrostatic attraction between the clot, vein wall, and radiopharmaceutical has been theorized.[5] Nevertheless, the "hot spots" invariably stand out in sharp, definite relief against the much lower level of background activity.

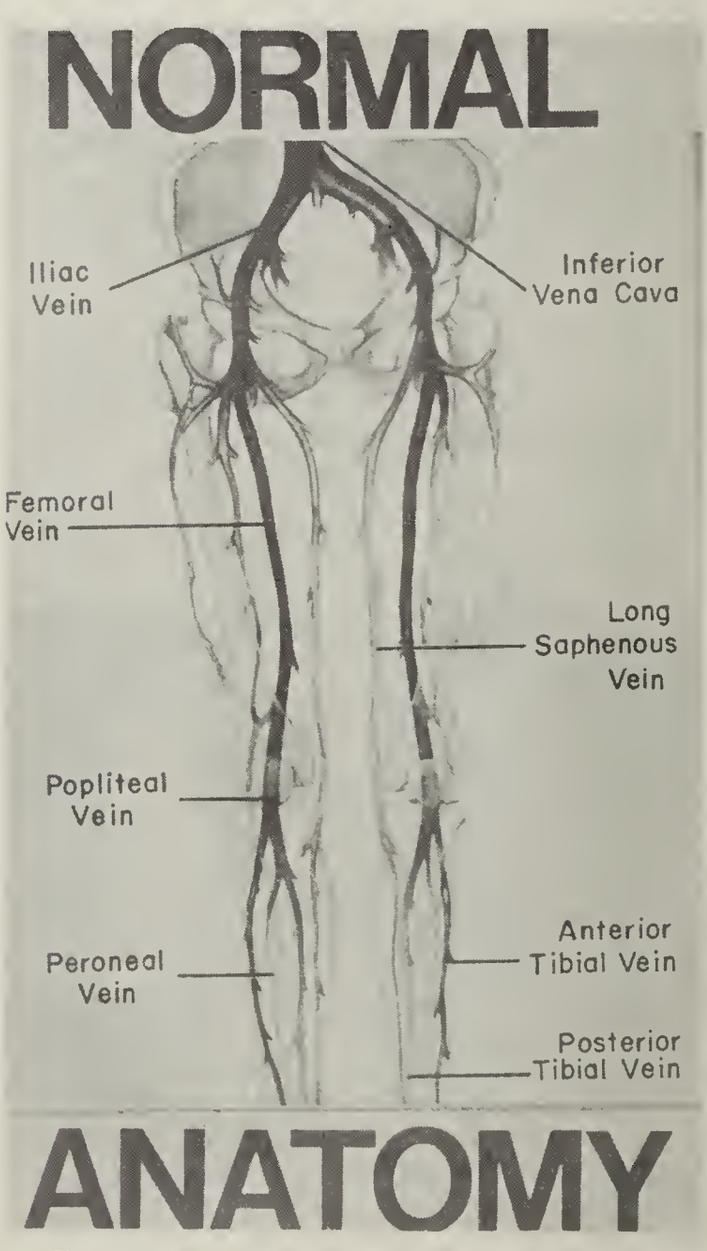


Figure 4. Normal lower extremity venous anatomy.

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.,* the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

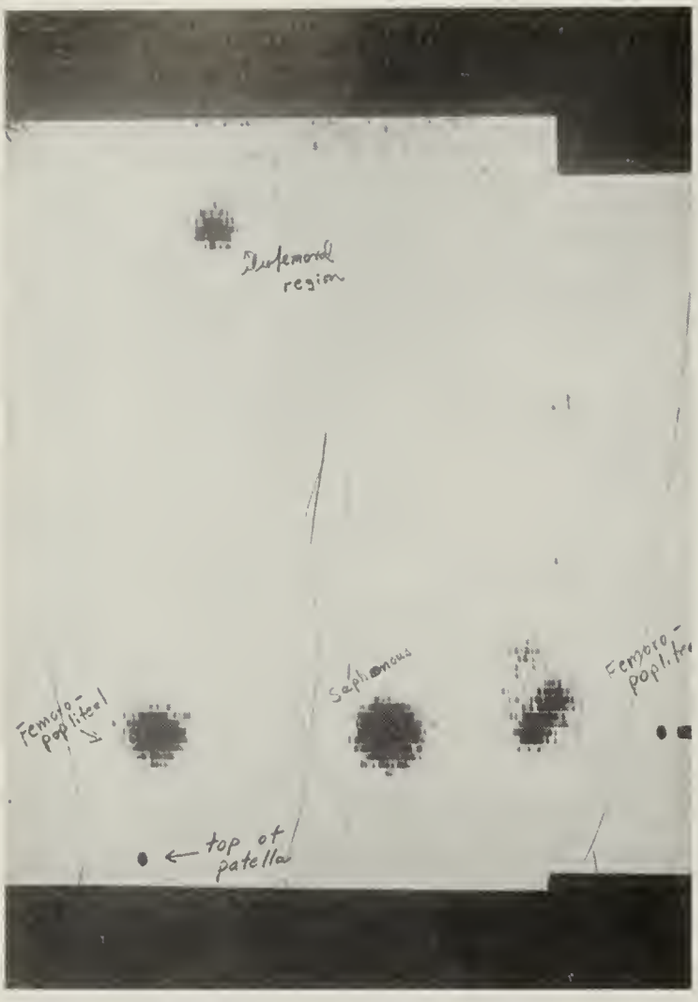


Figure 5. The isotope venogram in this case shows thrombotic disease in the right ilio-femoral and femoro-popliteal regions as well as in the left saphenous vein and femoro-popliteal region. The likely sources of multiple pulmonary emboli are demonstrated.

If lower extremity contrast venography is contemplated, injection of the Technetium 99M labeled Microspheres might best be accomplished through a 19 to 21 gauge needle with the needles taped in place for subsequent injection of iodinated contrast medium. Results of isotope venography in detection of deep venous thrombi have been shown to correlate with contrast venography in 96 per cent of cases.[6] The accuracy of radionuclide venography in detection of thrombotic disease in the ilio-femoral region may actually exceed contrast venography due to dilution of the contrast medium and to the superimposed bony pelvic and hip structures.

In summary, while the precise mechanism of accumulation of Technetium 99M labeled Albumin Microspheres at the sites of lower extremity venous thrombi (following dorsalis pedis intravenous injection) is unknown, such thrombi can now often be identified by isotope venography. Radionuclide venography is accurate in comparison with contrast venography and can be performed simply, with minimal equipment, and at essentially no risk to the patient. It is a rapid and reproducible method which helps determine the origin of pulmonary emboli and the extent of lower extremity venous disease. Demonstration of these venous thrombotic disease foci in individuals suspected of having pulmonary emboli can assist greatly in planning the subsequent medical or surgical management of these patients. ★★★

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A friend once asked a bigtime college coach why he didn't ask for a lifetime contract. The Coach replied, "I knew one coach with a lifetime contract. After two bad years, the university president called him into his office and pronounced him dead."

Counsel to Authors

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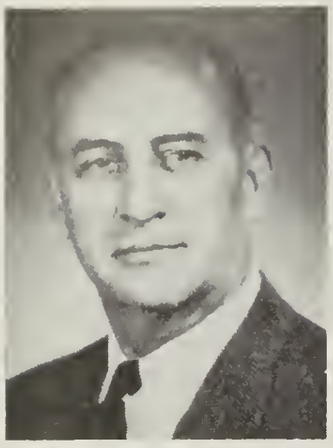
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The President Speaking

"Professional Responsibility"

J. T. DAVIS, M.D.
Corinth, Mississippi

IN THIS DAY of increasing cynicism and waning credibility, the crisis in professional liability has become a nightmare to the medical profession, to the insurance industry a field of diminishing returns and decreasing interest, but to the less discreet members of the legal profession a happy hunting ground.

The physician finds himself cautiously maneuvering to avoid pitfalls in a quagmire of regulations that surround him, and in the end practicing "defensive medicine" instead of devoting his time and talents to the needs of his patients.

Many insurance companies have discontinued malpractice coverage, while others have boosted premiums to astronomical heights.

The plaintiff's attorney, encouraged by jury verdicts and lucrative settlements, continues to conclude that the physician is easy prey, made vulnerable by strained doctor-patient relationships following entry of the Federal Government and third party payers into the health care field.

Other outside influence has been certain consumer organizations and special interest groups whose cries of "change the system," "patient's rights," and "socialized medicine" have reached the ears of Congress—creating a sense of distrust and cynicism.

To the public and to the politician the rash increase of malpractice litigations infers that the physician is delivering less than quality medical care, has grown more irresponsible in his "dollar oriented" practice and less responsive to the needs of his patients. All this tends to widen the credibility gap and serve as a basis for further legislative controls.

Clearly the time has come for the physician to pull his head out of the sand and recognize the moral and professional responsibility to do something about his dilemma.

Good rapport between doctor and patient is paramount and is a logical point to begin. This is an area under the direct control of the physician in which positive steps can be taken. Good public relations exercised by the office receptionist, nurse and finally by the doctor may serve as one's best defense. To communicate with a sense of kindness, warmth and understanding in addition to one's records reflecting concern and quality care may prove to be one's greatest asset in a court of law.

The Nork case in California, a stigma to the medical profession, should clearly point up the need for peer review and serve as a warning to those responsible for granting and delineating hospital privileges.

Attention to all these may not be enough to stem the rising tide

(Please turn to page 453)

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XV, NUMBER 10
OCTOBER 1974

EDITORIALS

Your *Journal MSMA*

Prior to 1960 your State Medical Journal was called the *Mississippi Doctor*. Under the editorship of Dr. W. H. Anderson of Booneville, Miss., a gracious and dedicated physician, who received many acclaims during his lifetime, the *Mississippi Doctor* served the M.S.M.A. as its official journal for many years.

In 1959, under the guidance of Dr. Lawrence Long, publications chairman, and Rowland Kennedy, managing editor, the JOURNAL M.S.M.A. format was developed much as you see it today. It took on a "new look" and many features were added. The JOURNAL is indebted to many people who have made contributions to its success but particularly to Mr. Kennedy who nearly singlehandedly "got it off the ground." Before he left the organization in 1972 he was responsible for training our present managing editor, Mrs. Nola Gibson. Recently the JOURNAL was awarded the 1974 *Award of Merit for Best Overall Magazine* by the Mississippi Editors and Directors of Information Association—an honor all of the staff can appreciate and I think not undeserved. Mrs. Gibson deserves particular credit.

None of your dues dollars have gone to support your JOURNAL. In the past it has been a somewhat profitable operation for your association and in addition has afforded much communication with the membership without cost to the association. With increasing cost of printing, newsprint and salaries and decreasing drug advertising it still has been able to maintain financial independence. This is no mean feat in itself. It has certainly been an asset to our organization.

W. MONCURE DABNEY, M.D.
Editor
Crystal Springs, Miss.

An Expanded Role for the RN

The Mississippi State Medical Association and Mississippi Nurses Association Joint Practice Committee will work with concerned professional licensing agencies to implement an expanded role for the registered nurse in Mississippi.

House Bill 436 which was sponsored by the medical and nursing associations and passed by the 1974 Mississippi Legislature authorizes an expanded clinical role for the registered nurse based on training and experience.

Exact procedures for implementing House Bill 436 are to be promulgated by the Mississippi State Board of Health and the Mississippi Board of Nursing. The MSMA/MNA Joint Practice Committee will serve in a consultant role to the two Boards.

Basically the chain of approval for an expanded role for a registered nurse would work something like this: that hospital administration, medical, and nursing staff or physicians in private practice desiring to use a qualified nurse in an expanded clinical role would furnish his or her credentials to the licensing boards and a description of the proposed role. Based on approval under rules and regulations to be promulgated by the two Boards, the Mississippi Board of Nursing would then "certify" the nurse for the proposed expanded role.

Members of the Mississippi State Medical Association and Mississippi Nurses Association Joint Practice Committee are: J. P. Culpepper, III, M.D., Hattiesburg, chairman; Tom H. Mitchell, M.D., Vicksburg; Jack B. Campbell, M.D., Jackson; Richard H. Russell, M.D., New Albany; Ms. Oneita Dongieux, R.N., Jackson; Ms. Ruth Werner, R.N., Jackson; Ms. Grace Ferguson, R.N., Jackson; Ms.

Wyncma McGrew, R.N., Hattiesburg; Sister Elizabeth C. Harkins, R.N., Hattiesburg; Ms. Merle Rogers, R.N., Tupelo.

CHARLES L. MATHEWS
Executive Secretary

No Proof in the Pudding

After some two years of debate over how to redirect the Comprehensive Health Planning and Regional Medical Programs, the House Interstate and Foreign Commerce Subcommittee on Health has reported a bill to combine and expand the scope of the programs at the federal, state, and local levels.

H. R. 16204 would establish a 15 man National Council for Health Policy to develop national health policy to include among other tasks guidelines concerning the "appropriate supply, distribution, and organization of health resources and services, including health education services."

At the state level a Health Planning and Development Agency would be created with an advisory council, the majority of whose members must be consumers, to oversee local health planning activities by what are to be called Health System Agencies. The state agency would among other duties determine the need for all new as well as existing institutional health services. This will result in a "certificate of need" approach for all health institutions.

The Health Systems Agencies would be nonprofit private corporations with governing bodies composed of a majority of consumers. The agencies would make recommendations to the State Health Planning and Development Agency respecting the need for institutional health services in their respective areas. Both health planning and implementation functions would be assigned to the agencies to include authority over the use of federal funds under the Public Health Service Act and various other federal health programs.

Present Hill-Burton funding for modernization and construction of medical facilities would continue. However, construction assistance for new inpatient medical facilities would be limited to areas of recent rapid population growth as determined under regulations to be issued by the Secretary of HEW. The program would also be expanded to provide construction funds for free-standing outpatient facilities.

H. B. 16204 would create a highly structured planning, resource development, and regulatory program at the federal, state, and local level. The certification procedures for institutions together with proposed planning and development functions create new controls over the health field. There is no record of satisfactory experience with health planning bodies and regulatory agencies to justify the federal imposition of a program creating controls and regulation of the scope and type proposed in H. B. 16204. Further, the assignment of health planning and implementation responsibilities to a private corporation composed of a majority of consumers smacks of a program called OEO which Congress has just seen fit to dismantle.

CHARLES L. MATHEWS
Executive Secretary

Report of the Delegates to AMA

A change in the method of electing AMA Trustees, a definitive policy statement on PSROs, the need for additional safeguards to preserve the confidentiality of medical records, and new recommendations which affect the relationship between hospitals and hospital medical staffs were among the important items approved by Delegates at the 123rd Annual Convention in Chicago.

Meeting for a total of 19 hours and 38 minutes, the House acted on 66 reports and 137 resolutions for a total of 203 items of business.

The House approved bylaws changes which replace the "slot method" of electing trustees by the "simultaneous election of candidates to several positions of equal rank," in which all candidates run for board vacancies on a single ballot.

Under the new method, trustees for full, three-year terms are elected first, followed by the selection of trustees to fill unexpired terms. Election of the AMA president-elect, vice-president, and speaker and vice-speaker of the House remains on a separate basis. Delegates selected Max Parrott of Portland, Oregon, as president-elect.

Speculation over possible changes in PSRO policy by the House dominated the attention of those attending the convention, including the media.

During its day-long hearing on Monday, June 24, Reference Committee A considered two reports and 25 resolutions bearing on the issue, and estimated that 64 speakers addressed themselves to PSRO.

But on Wednesday, the Delegates—cognizant of

the hours of debate devoted to PSRO at Anaheim last December and in New York City last June—overwhelmingly voted (202 to 24) to terminate debate after a few minutes.

Then the House adopted a substitute resolution on PSRO proposed by the reference committee, whose members emphasized that the resolution provides the association with a "clear-cut, definitive position which cannot be misunderstood by anyone inside or outside this House of Delegates." The resolution:

—Instructs the Board of Trustees to seek constructive amendments to the PSRO program, particularly in potentially dangerous areas such as confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW.

—Directs the AMA to continue efforts to achieve legislation which allows the profession to perform peer review according to established medical philosophy and the best interests of the patient.

—Emphasizes that state associations which elect non-compliance with PSRO are not prevented from doing so by the new policy, but urges such associations to develop effective non-PSRO review programs embodying the principles endorsed by the profession as constructive PSRO alternatives.

The new policy also provides that in the event that the PSRO program does, in fact, adversely affect patient care or conflict with AMA policy, then "the Board of Trustees (will) be instructed to use all legal and legislative means to rectify these shortcomings."

Two statements on national health insurance were adopted after lengthy debate. One calls on the Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for their adoption."

During discussion, it was pointed out that the addition to the NHI policy does not affect AMA support for Medicredit, but is intended to stimulate new health insurance mechanisms. The second resolution calls on the AMA and component associations to work to detach "any national health insurance program from the controlling intrusions of existing PSRO laws and regulations."

The House adopted two resolutions bearing on drugs. One directs the AMA to continue its support of the pharmaceutical industry in efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy. The other resolution directs the AMA to "exert all efforts to amend or repeal the Kefauver-Harris" drug amendments of 1962, which gave the FDA broad new powers in drug manufacturing and marketing, and which critics of the FDA contend has tended to stifle the developing and marketing of new drugs in the United States.

The House went on record as being opposed to certain bills in Congress which would replace the federal "Health Professions Educational Assistance Act" which expired June 30. Under the bills, comprehensive health planning programs would be replaced with public utility type bodies which would control certain aspects of health education and health care delivery, and medical licensure. An amended resolution adopted by the House directs the Board of Trustees to mobilize AMA membership in opposition to offensive sections of the proposed legislation, and take strong actions on other fronts.

In other actions affecting physicians and the government, and other third parties, the House:

—Directs the AMA to seek an extension of from 30 to 90 days to respond to proposed health regulations printed in the *Federal Register*, and that government agencies using the *Federal Register* for rule-promulgating purposes be urged to hold public hearings on the merits of proposed legislation.

—Calls on the AMA to oppose the concept of claims rejection on the basis of "diagnostic admission" or "lack of medical necessity" without prior physician notification, and to recommend a peer review mechanism be established independent of the third-party carrier to review claim conflicts with such mechanisms to be established by existing medical foundations, medical societies or other independent peer review organizations.

—Requests the AMA to work with third parties to secure increased acceptance of the AMA uniform health insurance claim form, and urges state associations to encourage acceptance of the form by insurance commissioners, and, if necessary, through state legislation.

—Urges continued AMA efforts to prevent future imposition of government fee controls, and opposes the mandatory imposition of a "Healthcard" as the payment mechanism under the Administration's national health insurance plan, and

instead, reaffirmed the right of the physician to bill patients directly.

The House adopted two reports bearing on confidentiality of medical records. Report I of the Council on Medical Service describes a wide-ranging series of proposals to enable the medical profession and insurance companies to "maintain the confidentiality and security of patient information." Report S of the Board of Trustees notes that the Council on Legislation is developing model legislation as a guide to possible state legislation to preserve confidentiality, and that a model bill should be ready for consideration by the House at the 1974 Clinical Session in Portland, Oregon.

The House adopted the 104-page "Report on Physician-Hospital Relations, 1974," compiled by the Council on Medical Service and its Committee on Private Practice. An update of an earlier report made in 1964, the 1974 version contains 14 specific recommendations to cope with problems developing between some hospitals and their medical staffs. Among other things, the recommendations are aimed at protecting medical staffs against unilateral action by hospital governing boards relative to staff bylaws, rules, and regulations. The report was considered by the MSMA House of Delegates at our 106th Annual Session, May 1974.

Two informational reports dealing with possible guidelines for housestaffs in developing contracts in institutions in which they serve generated considerable discussion before Reference Committee C. Among those testifying were medical students, residents, faculty members, hospital directors, and members of the AMA's Board of Trustees and Council on Medical Service. Because of the importance and the complexity of the issues involved, the two reports, plus a revised report submitted by the Intern and Resident Business Session during the convention, were referred to the Board of Trustees for further study and consultation with appropriate groups. Delegates directed the Board to report back at the 1974 Clinical Session.

The House adopted a resolution calling for the AMA, through appropriate committees and councils, to assure due process for medical students, and requested a further report at the next clinical session.

Another resolution proposing guidelines for "Fair, Professional Relationships between Training Institutions and House Officers" (intended for inclusion in the essentials of approved internships, and residencies) was referred for further study and report back at the clinical session.

The House adopted a resolution calling on the AMA to encourage—and urging medical schools to implement—a series of lecture programs for students on the socio-economic aspects of medicine.

The Mississippi State Medical Association Council on Scientific Assembly issues an **invitation** for **abstracts** of **papers** from MSMA membership to be considered for the 107th Annual Session, May 5-8, 1975, at Biloxi. Papers by individuals will be given equal consideration with papers by representatives of groups or institutions. Please send 250 word abstracts for consideration to:

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, Mississippi 39216

Book Reviews

Application of Proteolytic Enzymes to Protein Structure Studies. By E. Mihalyi, Ph.D., 364 pages with illustrations. Cleveland: CRC Press, 1972. $32.50.

The author sets out to present a current picture of a process of interest to a wide variety of scientists such as immunologists, physiologists, pharmacologists, pathologists as well as food and industrial technologists. He aims at a unifying point of view and presents a comprehensive bibliography (1,322 references) of the English, French and German literature.

After summarizing present concepts of proteins and proteinases and relating structure to function, the author discusses enzymatic proteolysis including methodology and characterization of fragments. The relationship of proteolysis to denaturation and conformational change is dealt with at length. The action of specific exopeptidases and endopeptidases on native proteins is discussed in detail both regarding limited proteolysis and formation of large fragments.

This treatise will be a useful reference text for any scientist involved in protein chemistry. Enough detail on specific protein-enzyme interactions is provided with a good list of refcrences to satisfy most investigators. In attaining his unitarian concept, the author has not always presented a balanced view of controversial subjects but this is compensated for by the references. This major undertaking is clearly presented and well arranged.

WARREN N. BELL, M.D.
Jackson, Miss.

Handbook of Poisoning: Diagnosis and Treatment. Eighth Edition. By Robert H. Dreisbach, M.D., 517 pages with tables and index. Los Altos, Calif.: Lange Medical Publications, 1974. $6.50.

As I read through this book, I wondered why the seventh edition was not in our Emergency Room. This is a detailed handbook dealing with poisoning, from prevention to general management and specific treatment.

The inside cover begins with first aid measures that the layman may carry out and gives instructions on transporting the patient to the Emergency Room.

The first chapter is brief and deals with the prevention of poisoning.

Chapter Two deals with emergency procedures in the ER while Chapter Three deals with the diagnosis of poisoning. Chapter Four gives details in the general supportive management of poisoning (Convulsions, Coma, Fluids, Establishmcnt of Airways, Pulmonary Edema, Shock, Heart Failure, Cardiac Arrest, Renal Failure, Vomiting, Diarrhea, Abdominal Distention, Acute Dermatitis, Dialysis, etc.).

The following chapters are devoted to specific poisons—from Agricultural Poisons, Industrial Hazards, Household Hazards, and Medicinal Poisons to Animal and Plant Hazards. There is a brief discussion of each substance—its use, where found, mechanism of toxicity and pathology. This is followed by a discussion of clinical findings and treatment. A bibliography is listed at the end of each section.

This book will be found useful to anyone doing primary medical care, and I recommend a copy for all Emergency Rooms.

LOUIS C. LEHMANN, M.D.
Natchez, Miss.

The President Speaking / Continued

of litigation but it may well serve to plug the dike until "the powers that be" outside the medical professsion finally conclude that the cost of litigation as well as the impact upon the actual provision of medical care is not in the public interest. ★★★

NEW MEMBERS

MCCRARY, ROBERT HOPE, Hattiesburg. Born Arcadia, La., June 28, 1939; M.D., Louisiana State University School of Medicine, New Orleans, La., 1964; interned Confederate Memorial Medical Center, Shreveport, La., one year; otolaryngology residency, same, 1967-71; elected by South Mississippi Medical Society.

The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology



X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W.B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

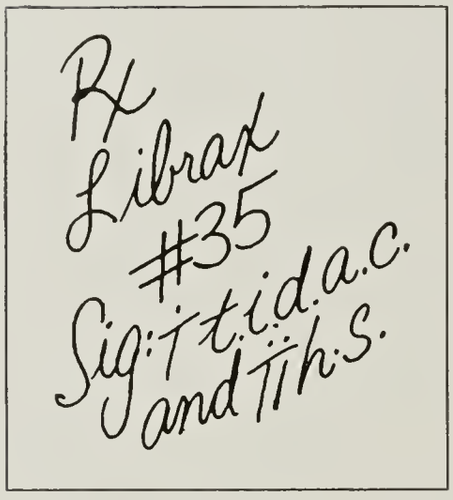
ROCHE

Please see summary of product information on following page.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Initial therapy

The initial prescription allows evaluation of patient response to therapy.



Follow-up therapy

Follow-up therapy with a prescription for 2 to 3 weeks' medication usually helps maintain patient gains.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan[T.M.])—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Medico-Legal Briefs

DRUG COMPANY NOT LIABLE FOR ADDICTION TO PAIN RELIEVER

In a suit against a drug company, a patient who became addicted to a pain reliever that was advertised as nonaddictive was denied recovery of damages by a California jury.

The patient, a 53-year-old woman, was given a prescription for Talwin by an orthopedic surgeon. The doctor later testified that he prescribed the drug because of its claimed nonaddictive quality.

The patient began taking the drug daily in November 1967, and became addicted in six months or a year. She continued to take it daily until it was withdrawn during a six-week period in a hospital psychiatric ward. The patient did not take the drug after the withdrawal but, because of continuing pain, took one daily dose of methadone from that time on.

The patient brought an action against the manufacturer of Talwin, contending that the company indicated that the drug was a strong pain reliever, with absence of addiction liability in premarket testing and not deemed a narcotic under Federal regulations. She contended that the original package inserts cited tests under the auspices of the Committee on Drug Dependence of the National Academy of Sciences that showed little if any addiction liability and indicated that Talwin was the first strong pain reliever for chronic use without danger of addiction.

The patient pointed to the history of other pain relievers that it had been hoped were nonaddictive, such as heroin, codeine, Demerol, and Darvon. She contended that it was negligent to claim absence of addiction liability without more widespread clinical use for chronic pain.

The patient further contended that the drug company knew by August 1968 that Talwin was addicting but did not give timely and adequate warning to the medical profession and continued heavy promotion of the drug. Although the package insert was changed in October 1968, to indicate the discovery of dependence potential, the company did not send a "Dear Doctor" letter until August 1969. She said that the statement of absence of addiction liability in the original labeling was an express warranty, which was breached by the company.

The drug company stated that before marketing they tested the drug in 17,000 people without any indication of addiction. They said that they performed every possible test under the auspices of the National Research Council without any indication of addiction potential. Following marketing, they said, they changed the labeling when they discovered that a very small percentage of the population became habituated to the drug.

The patient's motion for punitive damages was denied. The court instructed the jury on negligence and breach of express warranty but refused to instruct on strict liability or implied warranty.

The patient claimed drug addiction and destruction of her home life, as well as day-to-day craving. She said that her drug dependence resulted in her lying to physicians and cheating in order to obtain a sufficient amount of the drug. She altered prescriptions, went to numerous physicians at the same time, and told physicians of fictitious planned long vacations in order to obtain a large drug supply.

Physicians testifying for the drug company said that because of the nature of the patient's problems she required a strong analgesic. If Talwin was not used, they said, another addicting analgesic would have been required. They also stated that the patient had a history of drug abuse and had abused Talwin. —*Henry v. Winthrop Laboratories* (Cal.Super.Ct., San Francisco Co., Docket No. 627248, April 19, 1974)

PERSONALS

LEONARD A. BIBLE has opened a medical clinic in Mendenhall at the intersection of Pine Avenue and East Street.

RICHARD BUCKLEY announces the association of VICTOR T. BAZZONE for the practice of neurological surgery at Coastal Medical Center, P.A., Gateway Executive Park, P. O. Box 4080 in Biloxi.

CLAUDE G. CALLENDER of Jackson announces his return to practice at the Woman's Clinic, 918 North State Street.

GUY CAMPBELL of Jackson was visiting professor at Forrest General Hospital in Hattiesburg in August.

MICHAEL R. CASEY has associated with THOMAS R. HOWELL and CHARLES A. HOLLINGSHEAD in the Laurel Medical and Surgical Clinic at 103 South 12th Avenue for family practice.

The Radiological Group, P.A., of Jackson announces the association of KENNETH G. CARTER in the practice of radiology at 316 Medical Arts Building.

LAURENCE J. CLARK, JR., a native of Vicksburg, has assumed the duties of chronic disease consultant in the Bureau of Disease Control at the Mississippi State Board of Health.

RICHARD H. CLARK of Hattiesburg and RICHARD J. FIELD of Centreville have been appointed by Governor Waller to serve on the Emergency Medical Services Advisory Council.

Internal Medicine Associates, P.A., of Meridian announces the association of JOHN C. CLAY for the practice of internal medicine, hematology, and oncology at 1301 Twentieth Avenue.

ROBERT J. COLE of Amory has relocated his office at 303 2nd Avenue North in the Professional Building.

ROBERT D. CURRIER and BUREN S. SMITH of Jackson received the MS Award of Merit at the recent Multiple Sclerosis Awards Luncheon.

DAVID L. DUGGER has opened his offices on Vancleave Road in Ocean Springs for the practice of general and behavioral pediatrics. Dr. Dugger is a graduate of the University of Tennessee.

CLYDE A. ELLIS of Clarksdale announces the association of WILLIAM F. CLARK, JR., for the practice of radiology at the Northwest Mississippi Regional Medical Center.

The Field Clinic in Centreville announces the association of ROBERT FORSTNER for family practice and obstetrics.

LEWIS E. HATTEN has associated with J. P. CULPEPPER, III, and JOE E. VARNER, JR., of Hattiesburg for the practice of general and vascular surgery with offices at Medical Plaza Building, 2601 Mamie Street.

SAMUEL B. JOHNSON of Jackson and UMC lectured in August at the Law-Science Academy of America, Crested Butte, Colo., and at Southwestern Medical School in Dallas on Medical-Legal Ophthalmic and Disability Evaluation.

HENRY A. MCCRORY announces his association with the Woman's Clinic, P.A., FRANK T. MARASCALCO, DONALD R. ELLIS, and GLENN L. WEGENER in the practice of obstetrics and gynecology at 1967 Hospital Drive in Clarksdale.

The Vicksburg Clinic announces the association of CHARLES W. MCFATTER in the department of obstetrics and gynecology.

JAMES N. MCLEOD, III, announces the relocation of his office for the practice of internal medicine to Suite 415, St. Dominic Medical offices, 971 Lakeland Drive in Jackson.

DAN H. MOORE, E. LOWRY MOORE, and MICHAEL TALEFF of Meridian announce the association of WILLIAM W. EAST in practice limited to diseases and surgery of the eye at 1303 25th Avenue.

JOHN D. MORGAN and LARRY B. AYCOCK of McComb announce the opening of their new offices in the Medical Arts Building, 300 Rawls Drive.

CHARLES PARKER has associated with Drs. Segar, King and Draper in the Iuka Clinic.

BERNARD S. PATRICK of Jackson and UMC attended the executive committee meeting of the Congress of Neurological Surgeons in Atlanta.

O. D. POLK announces that his office is now located at 2311 Fourth Street in Meridian.

E. J. PRICE, JR., announces the removal of his office for the practice of obstetrics and gynecology to the Medical Arts Building, corner of Aston Avenue and Rawls Drive in McComb.

Drs. Riley, Thornton, Tucker and Billups of the Medical Arts Surgical Group, Ltd., announce the removal of their offices to 2111 Fourteenth Street in Meridian.

WILLIAM G. RILEY, JOHN D. MCEACHIN and WILLIAM M. HILBUN of Meridian announce the association of WILLIAM B. SIMMONS in the practice of pediatrics at the Medical Arts Clinic, 2115 14th Street.

HENRY J. SANDERS announces the opening of his office for the practice of ophthalmology in the Medical Arts Building on Aston Avenue in McComb.

RICHARD J. SCHUNIOR announces the relocation of his Picayune office to 739 Gause Blvd., Slidell, La., for the practice of general surgery.

CLIFFORD A. SEYLER announces the opening of his

office for the practice of pediatrics at Suite 205, Doctors Plaza in Pascagoula.

R. Arnold Smith announces the opening of his fulltime practice in radiation therapy at Mississippi Baptist Hospital in Jackson.

Augustus P. Soriano has opened his clinic at 229 Peachtree Avenue in Philadelphia for family practice and surgery.

William A. Spencer announces the association of Arthur Boyd in the practice of medicine and surgery at the Sardis Family Clinic adjacent to North Panola County Hospital.

W. Granville Tabb, Jr., announces the relocation of his office for the practice of ophthalmology to Suite 614, Medical Arts Building, 1151 North State Street in Jackson.

Robert Thompson of Laurel spoke to the Rotary Club recently on his recent medical mission trip to the Southern Texas border.

John D. Wofford of Greenwood was named Physician of the Year and presented a plaque at the eighth annual convention of the Mississippi Medical Assistants Society held in Greenwood. Howard A. Nelson of Greenwood introduced guest speaker J. T. Davis of Corinth at the meeting.

POSTGRADUATE CALENDAR

Sept. 30-Oct. 4, 1974

Electrocardiography Intensive Course

University Medical Center, Jackson
Sept. 30, Oct. 1-4, 1974, beginning at 9:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
Thomas M. Blake, M.D., professor of medicine, the University of Mississippi School of Medicine

The course will consist of a series of discussions of selected topics in electrocardiography chosen on the basis of their immediate clinical applicability. Electrocardiograms, slides, and other visual aids will be used generously, and participants will have the opportunity to interpret electrocardiograms, raise questions, and suggest specific topics for consideration. Interpretation of tracings will be emphasized.

Oct. 10

Pulmonary Disease Seminar

University Medical Center, Jackson
Oct. 10, 1974

Sponsored by Mississippi Thoracic Society, Mississippi Lung Association, and the University of Mississippi Medical Center Division of Continuing Health Professional Education

Coordinator:
Joe R. Norman, M.D., professor of medicine, (Christmas Seal Professor of Pulmonary Disease; director, Pulmonary Division) and associate professor of physiology-biophysics, the University of Mississippi School of Medicine

Discussions on obstructive and lung function testing, the clinical application of arterial blood gases, and prevention of postoperative pulmonary complications will be presented in this one-day seminar. A practical demonstration of pulmonary physical therapy is also planned.

Oct. 17-18

Southeastern Immunology Workshop

Medical Center Holiday Inn, Jackson
Oct. 17-18, 1974, beginning at 8:45 a.m.

Hosted by the University of Mississippi Medical Center

Coordinator:
James B. Grogan, Ph.D., professor of surgery (research) and associate profcssor of microbiology, the University of Mississippi School of Medicine

Gregory Butchko, Ph.D., assistant professor of microbiology, the University of Mississippi School of Medicine

The course will consist of addresses by prominent immunologists on recent findings in the field of immunology. Exhibits and round table discussions will also be an integral part of this seventh annual workshop.

Oct. 28-Nov. 1, 1974

Neurology and Neurosurgery Intensive Course

University Medical Center, Jackson
Oct. 28-31, Nov. 1, 1974, beginning at 8:00 a.m.

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
Robert C. Currier, M.D., professor of medicine, the University of Mississippi School of Medicine, and co-director of the stroke unit of the Mississippi Regional Medical Program
Armin Haerer, M.D., associate professor of medicine, the University of Mississippi School of Medicine, and co-director of the stroke unit of the Mississippi Regional Medical Program

Content will include the management of adult and children's neurological and neurosurgical disorders. Material will be presented in seminars, discussion groups, and assigned reading and rounds on the wards and clinics in the University Hospital. Rehabilitation techniques will be included.

Nov. 4-8, 1974

HEMATOLOGY-ONCOLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 4-8, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
Francis S. Morrison, M.D., associate professor of medicine and director of division of hematology, the University of Mississippi School of Medicine

Recent advances in oncology as well as the basics of diagnosis and therapy will be presented. Supportive management such as advances in component and problems of infection in immunosuppressed patients will be emphasized. Newer developments in hematology will also be covered.

Nov. 4-8, 1974

UROLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 4-8, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
W. Lamar Weems, M.D., associate professor of surgery and director of division of urology, the University of Mississippi School of Medicine

The emphasis of this course will be on practical urology as it relates to the nonurologist. The latest concepts and practices in common urologic diseases will be presented.

Nov. 11-15, 1974

CARDIOLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 11-15, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
James R. Galyean, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

The course will familiarize physicians with current concepts in bedside diagnosis of heart disease. Practical points in physical diagnosis and review of the various forms of heart disease will be covered using aids such as pulse tracings, phonocardiograms, electrocardiograms, x-rays, and hemodynamic data in illustration. Participants will round, watch cardiac catheterizations, and enter into team discussions on patient management. Reasons for suggesting or rejecting surgery will be discussed in detail. A cross section of cardiac diagnoses will be reviewed.

Nov. 18-22, 1974

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 18-22, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
John D. Bower, M.D., associate professor of medicine and director of the artificial kidney unit, the University of Mississippi School of Medicine

This clinically oriented course will emphasize the reversible and treatable forms of kidney disease. The management of acute kidney failure and the control of the reversible features of chronic kidney disease will be presented in depth. The management of pyelonephritis, glomerulonephritis, nephrotic syndrome, fluid and electrolyte problems, and acid-base balance will be covered. The par-

ticipants will become familiar with physiology, pathology, radiology, immunology, urology, transplantation and hemodialysis in clinical nephrology.

FUTURE CALENDAR

Sept. 30-Oct. 4
Electrocardiography Intensive Course

Oct. 10
Pulmonary Disease Seminar

Oct. 17-18
Southeastern Immunology Workshop

Oct. 28-Nov. 1
Neurology and Neurosurgery Intensive Course

Nov. 4-8
Hematology-Oncology Intensive Course

Nov. 4-8
Urology Intensive Course

Nov. 11-15
Cardiology Intensive Course

Nov. 18-22
Nephrology Intensive Course

Jan. 27-31 (Tentative)
EKG Intensive Course

Feb. 10-14
Urology Intensive Course

Feb. 17-21
ENT Intensive Course

Mar. 3-7
Hematology Intensive Course

Mar. 13-15
Surgery Conference

April 7-11
Pulmonary Medicine Intensive Course

April 14-18
Nephrology Intensive Course

April 21-25
Radiology Intensive Course

Tentatively scheduled are one-week intensive courses in neonatology and pediatrics.

All intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, pharmaceutical firms, volunteer health agencies, and private donation. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged for each.

44 State Doctors Get AMA CME Award

In August the Executive Secretary, President and Chairman of Continuing Medical Education at Mississippi State Medical Association (MSMA) received two print-outs from AMA's Department of Continuing Medical Education, listing 44 recipients of the 1973 AMA Physician's Recognition Award.

The award is a voluntary CME program designed to improve physician competence and recognize physicians active in CME. In 1973, 12,488 physicians qualified for the award; with 23,986 now holding currently valid certificates.

MSMA plans to use this information, made available only to state medical and medical specialty societies, in a number of capacities:

1. To verify that individual physicians qualified for the award;
2. To recognize physicians for personal CME activities;
3. To document professional leadership in CME for legislative committees and licensing agencies—demonstrating that a mandatory CME requirement is unnecessary;
4. To help plan and evaluate current CME programs; and
5. To encourage membership in MSMA.

As MSMA members, you should be aware of the many advantages to earning the award. If you qualify by completing 150 hours of CME every three years, 60 of which must be earned in AMA-approved, Category I credit, you may use the award for:

a. Reviewing, evaluating, planning your personal CME program;

b. Completing administrative reports, tax records, etc.;

c. Maintaining hospital staff privileges, status as a consultant or an academic appointment;

d. Documenting participation in CME as required or recommended by your: (1) group practice; (2) peer review or self-assessment programs; (3) recertifying body; (4) relicensing board; (5) local, state or medical specialty society for continued membership.

For further information about the award program, contact MSMA or AMA's Department of Continuing Medical Education, 535 N. Dearborn, Chicago, IL 60626.

MSMA Board Conducts Summer Meeting

The Board of Trustees of the Mississippi State Medical Association held its regular summer meeting in August. Meeting also was the Board of Directors of the Mississippi Foundation for Medical Care.

Primary business coming before the MSMA Board was:

- Referrals from the recent 106th Annual Session of the association dealing with proposed legislation to be sought during the 1975 Regular Session of the Mississippi Legislature;
- A report from the Council on Scientific Assembly concerning planning for the 107th Annual Session;
- A review of the St. Paul Professional Liability Insurance Program;
- The MSMA Delegates' report concerning the June AMA meeting;
- Approval of legal action against the Mississippi Board of Chiropractic Examiners; and
- A request from the Mississippi Medicaid Commission for peer review of services provided by physicians paid over $100,000 annually by the program.

The Board referred to the Council on Legislation actions by the House of Delegates seeking certification of physician assistants by the State Board of Health, legal standards for HMOs, modernization of current admission laws to mental hospitals, and a 28 day life span for CPD preserved blood.

The Council on Scientific Assembly recommended and the Board approved shortening of the association's annual session by conducting the closing meeting of the House of Delegates on Thursday morning instead of the afternoon. Additionally, most scientific sessions will be conducted in the mornings during the annual session and the association will reestablish the annual association party which was dropped several years ago.

Representatives of the St. Paul Insurance Company appeared before the Board to present a report on the MSMA-St. Paul Professional Liability Insurance Program. The Board reviewed underwriting data on the program which indicated the necessity for a 25 per cent premium increase effective October 1974. The Board noted that the program continued to be one of the most efficient in the country and directed that the association join the St. Paul Company in strengthening educational programs for Mississippi physicians concerning professional liability prevention.

MSMA Delegates to the AMA, Dr. G. Swink Hicks of Natchez and Joseph B. Rogers of Oxford, reported on the June 1974 meeting of the AMA. Their report, which is printed in this JOURNAL, emphasizes the change in AMA policy regarding the Professional Standards Review Organization (PSRO) Program from one of implementation and repeal to one of implementation and change based on experience in the conduct of the program.

The Board authorized legal action against the Board of Chiropractic Examiners based on that Board's actions to enforce the requirements of the Chiropractic Licensing Act pertaining to advertising, use of the title "Dr.," and scope of practice.

At the request of the Mississippi Medicaid Commission, the Board directed the association's Committee on Peer Review to conduct professional review of services provided by physicians paid over $100,000 annually by the Medicaid program.

In other activities the Board reviewed the status of a uniform claim form for physician services in Mississippi as required by action of the 1974 Regular Session of the Mississippi Legislature, authorized financial and staff support for the "Physicians Placement Bulletin" published by the Ole Miss Medical Alumni Association in cooperation with MSMA, and reviewed the Jackson television station WAPT-MSMA sponsored program "House Call."

The fall meeting of the Board was scheduled for December.



Council on Scientific Assembly Announces New Format for 107th Annual Session

A condensed schedule of scientific meetings was among preliminary plans for the 107th Annual Session to be held in Biloxi, May 5-8, 1975, decided upon by the Council on Scientific Assembly in a summer planning meeting, according to Dr. James P. Spell of Jackson, chairman.



Dr. Spell

On the annual session meeting agenda are the House of Delegates and reference committees for Monday with the final meeting of the policy-making body scheduled for Thursday morning.

The eight scientific sections will again offer top guest essayists with emphasis on instate participation. On Sunday night, May 4, the Section on Anesthesiology will meet. Tuesday morning, May 6, will feature simultaneous meetings of the Section on Family Practice and the Section on EENT. That afternoon the Section on Surgery and the Section on Preventive Medicine will meet. On Wednesday morning the Sections on Internal Medicine, Ob-Gyn and Pediatrics will meet concurrently.

Dr. Spell said that as many as 15 specialty societies and related groups will meet concurrently with the annual session, usually selecting a day adjunctive to general scientific meetings concerned with the particular specialty. Of further interest will be specialty society luncheons and dinner occasions.

The Woman's Auxiliary will meet concurrently with the MSMA annual session for its 52nd annual session. Mrs. Dan Reikes of Hattiesburg is president.

Dr. Spell said medical alumni groups representing Ole Miss, Tulane, Tennessee and Vanderbilt are scheduling social occasions. Ole Miss will meet on Monday, May 5, both in a business session and for an evening dinner and dance party. Tulane, Vanderbilt and Tennessee medical alumni will meet on Tuesday, May 6, Dr. Spell said.

Special events will include the Fifty Year Club luncheon and Past President's breakfast. The annual association party will be reestablished for the 1975 meeting.

Delegates will meet on Monday to receive reports and resolutions which will be discussed before reference committees that afternoon. Dr. J. T. Davis of Corinth, MSMA president, will open the convention. The Nominating Committee will conduct open sessions on Wednesday, and on Thursday, the House will take final actions on business and policy, electing 1974-75 officers as the final order of business.

Dr. Jack A. Atkinson of Brookhaven, president-elect, will be inaugurated 1975 president at the adjourned meeting of the House of Delegates, and new officers will assume their respective posts at that time.

Technical and scientific exhibits will also be featured during the four-day annual session.

MFMC Board Met in August

The Board of Directors of the Mississippi Foundation for Medical Care held a meeting in August to review PSRO implementation plans for Mississippi as funded by the Department of HEW.

The full 20 member Board heard reports from the president of the Mississippi State Medical Association, Dr. J. T. Davis of Corinth, and the chairman of the PSRO Executive Committee, Dr. Tom H. Mitchell of Vicksburg, concerning PSRO organizational activities, funding, and review mechanisms being formulated for consideration by Mississippi physicians.

The Board approved the conduct of educational programs concerning PSRO for physicians in the state during the fall. The programs will be conducted at hospital staff and medical society meetings.

The Board also confirmed nominating procedures for election of a Board of Directors by the Foundation membership as required by the PSRO Program. Nominees for the Board will include physicians serving on the present Foundation Board as well as those physicians composing the Subcommittee on PSRO Planning which drafted the Foundation's PSRO application.

In other activities the Board received a report from its Committee on Minimum Standards Contracts for Health Insurance Policies and directed that a proposed "Minimum Standards Contract" be offered for consideration by Blue Cross and Blue Shield of Mississippi preparatory to a final contract being considered by the Board of that organization and the membership of the Foundation.

Members of the MFMC Board of Directors are: Drs. James O. Gilmore, Oxford, chairman; Everett Crawford, Tylertown; Gerald P. Gable, Hattiesburg; Lyne S. Gamble, Greenville; Robert S. Caldwell, Tupelo; Arthur A. Derrick, Jr., Durant; Carl G. Evers, Jackson; Joe S. Covington, Meridian; James T. Thompson, Moss Point; Millard S. Costilow, North Carrollton; Sidney O. Graves, Jr., Natchez; Whitman B. Johnson, Jr., Clarksdale; Tom H. Mitchell, Vicksburg; J. T. Davis, Corinth; J. P. Culpepper, Hattiesburg; James W. Rayner, Oxford; William H. Preston, Jr., Booneville; Richard C. Miller, Jackson; C. D. Taylor, Jr., Pass Christian; and Kenneth P. Pittman, Jackson.

MPAC Supports Incumbents

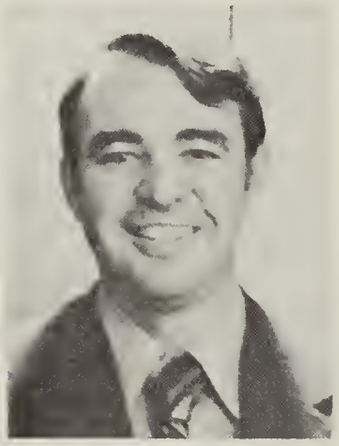
The Mississippi Political Action Committee will support those members of the Mississippi congressional delegation facing opposition in the November general elections.

MPAC's Board of Directors has officially confirmed contributions to the campaigns of Mississippi Congressmen David Bowen, Thad Cochran, and Trent Lott in their reelection bids for Mississippi's 2nd, 4th, and 5th Congressional Districts respectively. The American Medical Political Action Committee will also support Mississippi's incumbent congressmen in their reelection campaigns.

Members of the MPAC Board are: Drs. L. Stacy Davidson, Jr., Cleveland, chairman; John R. Young, Jr., Natchez; John R. Lovelace, Batesville; Lawrence H. Brisco, Tupelo; Mike C. Campbell, Grenada; J. Elmer Nix, Jackson; Austin P. Boggan, Decatur; W. W. Walley, Waynesboro; Jack C. Hoover, Pascagoula; and Mrs. Thomas L. Ketchum, Ripley.

Dr. Hilbun Named to State Board of Health

Dr. Benton M. Hilbun of Tupelo has been appointed to the Mississippi State Board of Health by Governor William Waller. Dr. Hilbun will serve a six-year term, according to Dr. Alton B. Cobb, State Health Officer.



Dr. Hilbun

He replaces Dr. DeWitt T. Hamrick of Corinth as a physician on the board.

Dr. Hilbun is a native of Lucedale and graduated from the University of Mississippi School of Medicine in 1961. He interned and completed a residency in general and thoracic surgery at the University Medical Center in Jackson.

He has been in practice in Tupelo since July 1, 1967. Dr. Hilbun is a member of MSMA, North Mississippi Medical Society, AMA, and Mississippi Thoracic Society. He served as an MSMA vice president and was certified by the American Board of Surgery in 1967.

Nurse Practices Family Planning

Her patients call her "Doctor Lady."

And although she is not a physician, Mrs. Diane Armstrong is no longer a general public health nurse. She's a specially trained, family planning nurse practitioner—the first one in Mississippi.

She works directly under a physician's orders and performs duties that until recently would only be conducted by a licensed physician, including taking the patients' medical history, patient examinations, prescribing oral contraceptives, inserting intrauterine contraceptive devices under proper circumstances, fitting diaphragms, and treating minor medical problems.

But Diane Armstrong does more than her orders instruct her to do. She takes an interest in her patients that is sometimes rare—and her program's success is attested by the fact that last year "Doctor Lady" saw over 900 patients in seven clinics in Harrison, Pearl River and Hancock counties.

"There's more to family planning than the strict medical duties," she said, "It's a personal thing and when you deal with people there must be interaction between you—you must talk and advise, and you must listen."

"Family planning is an attitude and I like to think that our program is open and responsive," Mrs. Armstrong added.

Her patients vary in age from 14 to 81, and she takes time with each of them.

"Each patient is an individual and as such, each and every one of them has a different problem that must be dealt with," she said.

"Since I've been practicing these past two and one half years, I've seen a lot more teenagers than I really expected to see," she said. "Most of them are afraid to confront their parents with their problems and they have to go to someone who will listen and advise them sensibly."

"And if they need medical help, we give it to them," she added. "If I can't handle the problem or if it doesn't fall under my standing orders, I refer the patient to a physician."

A good working relationship with local physicians and hospitals is essential for the family planning program to work and Mrs. Armstrong feels that she has just that.

"When I first began seeing patients, I think that a lot of our local physicians saw my role as one that was attempting to put them out of business," she said. "But that stream of thinking quickly changed and now we have a marvelous working relationship."

The role of the nurse practitioner or extender is not to relieve physicians of their responsibilities, rather the position itself stems from the shortage of physicians, not only in Mississippi but throughout the United States.



Mrs. Diane Armstrong, Family Planning Nurse Practitioner, discusses a case with Dr. Louis Jobe, Harrison County Health Officer. Mrs. Armstrong works under standing orders from the county health officer.

Mrs. Armstrong received her specialized training at the University Medical School in Jackson. To date nine family planning nurse practitioners are working for the MSBH.

"Requirement for entrance was that you be a registered nurse with two years of experience," she said. "And the special training is approximately six months."

"It's been a rewarding experience and I don't just hope that we've begun solving some problems in the family planning area of public health work—I know that we have," she said.

This Is Immunization Action Month

October is national Immunization Action Month. MSMA is one of the many sponsoring organizations in Mississippi.

A special effort is aimed at notifying physicians and their staffs of the importance of auditing the immunization needs of each patient. Mr. Paul Turner, who heads the IAM effort at the State Board of

Health, reports that immunization levels are getting dangerously low, especially polio immunizations.

The goals of Immunization Action Month are:

1. To alert the citizens of Mississippi to the need for diphtheria, pertussis, tetanus, polio, measles, rubella and mumps immunizations, especially among preschool children.

2. To reverse the alarming decline in immunization levels, especially the level of DPT and Polio.

3. To encourage adults to personally audit their own immunization records and also the immunization records of their children and to seek immunizations as needed.

4. To motivate both private and public health personnel to audit each and every patient's immunization need as determined by record and history.

5. To encourage and promote the passage of legislation that requires every first-grade child, regardless of school system, to be completely immunized against vaccine preventable diseases as recommended by the State Board of Health.

6. To establish an on-going educational and informational program that will constantly emphasize the importance of immunizations as a major part of preventive health.

IMMUNIZATION ACTION MONTH

This is the symbol used to promote National Immunization Action Month.

UMC Med Students Up 13 Per Cent



Enrollment at the University of Mississippi School of Medicine climbed to 489 this fall, a 13 per cent jump over last year's 432. Among the 150 first year students, the largest class in history, are, from left, Curtis Edward Kersh of Cleveland, Felton Eugene Combest, Jr., of Greenville, and Wilkins Winslow Dedwylder, Jr., of Cleveland. Total enrollment for all programs at the University Medical Center reached 1,260, an overall increase of 15 per cent.

UMC Hosts Immunology Workshop

The University of Mississippi Medical Center will host the Seventh Annual Southeastern Immunology Workshop Oct. 17 and 18 at the Medical Center Holiday Inn.

Some 150 physicians and medical scientists from the southeast and other invited guests from various sections of the country are expected to participate. Dr. James B. Grogan, associate professor of surgery (research) at the Medical Center, and Dr. Gregory Butchko, assistant professor of microbiology, are program coordinators.

Opening day of the session will feature Dr. Ingegerd Hellstrom, professor of microbiology, University of Washington, Seattle, Wash.; Dr. Franklin P. Inman, associate professor of microbiology, University of Georgia, Athens, Ga.; and Dr. John K. Spitznagel, professor of bacteriology and immunology, University of North Carolina School of Medicine, Chapel Hill, N. C.

Second day speakers are Dr. Alfred Nisonoff, professor and chairman of the department of biological chemistry, University of Illinois College of Medicine, Chicago, Ill.; Dr. Bruce Glick, professor of poultry science, Mississippi State University; and Dr. David H. Katz, associate professor of pathology, Harvard Medical School, Boston, Mass.

Registrants will also participate in one of four round table discussions: T and B cell interaction, phagocytic cell function, cancer and transplantation immunology, or immunoglobulins.

Dr. Pierce Speaks at Pulmonary Seminar

Dr. Alan K. Pierce of Southwestern Medical School will be guest speaker at the Oct. 10 pulmonary disease seminar at the University of Mississippi Medical Center.

Dr. Pierce is on the Department of Medicine faculty at the Dallas, Texas, school.

Sponsors of the event are Mississippi Thoracic Society, Mississippi Lung Association, and the Division of Continuing Health Professional Education at the Medical Center.

Dr. John R. Williams of Greenville, president of the state Thoracic Society, said the day-long event will be interrupted only by sandwich seminars at noon. Registrants may choose to stay at one of the small groups, or move from table to table and participate in several various discussions.

Further information can be obtained by writing Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, Miss. 39216.

ACS Seeks to Eliminate Uterine Cancer

This year 700 Mississippi women will die of uterine cancer. These deaths need not happen. Physicians agree that this cancer is 100 per cent curable most of the time if detected in its early stages.

Aimed at eliminating these needless deaths, the American Cancer Society, Mississippi Division, is launching a concentrated statewide program of combative action.

The Uterine Task Force seeks to eradicate needless deaths due to undetected uterine cancer by educating the women of Mississippi to the need of an annual Pap smear and helping those in need to secure the cancer screening test.

Under the volunteer leadership of Dr. Loren Breland of Crystal Springs, president of the Mississippi Division; and Dr. Thomas Barnes of Greenville, volunteer chairman of the Uterine Task Force, the Uterine Task Force will work to take the message of the life-saving habit of an annual Pap smear into every area of Mississippi.

Medical Education Changes Proposed

The Senate Labor and Education Committee has approved a revolutionary medical education bill that would require all medical graduates to serve in shortage areas and compel relicensing of all physicians.

S. 3585, written by the Health Subcommittee headed by Sen. Edward Kennedy (D. Mass.), carries almost $1 billion in federal aid for medical and other health schools over the next five years.

In addition to the controversial mandatory service and relicensing provisions, the bill gives the federal government power to allocate and limit postgraduate training positions for physicians. Designed to curb reliance on foreign medical graduates and to increase the numbers of primary care physicians, the disputed provision also requires the Secretary of Health, Education and Welfare to limit the number of postgraduate physician training positions to no more than 10 per cent above the number of domestic medical and osteopathic school graduates that year. The HEW Secretary would assign the total number of certified positions established to the various categories of specialty and subspecialty practice of medicine.

The Association of American Medical Colleges and the AMA were sharply critical of these provisions. Similar legislation now before the House is not expected to contain them. Eventual fate will probably hinge on the outcome of a House-Senate conference.

FMGs Are Criticized

A slashing attack against the nation's reliance upon foreign medical graduates has been launched by the Association of American Medical Colleges (AAMC).

The present situation "undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people," according to a report by an AAMC task force on FMGs headed by Kenneth Crispell, M.D., vice president for health affairs at the University of Virginia.

Endorsed by the AAMC executive council, the blunt assault on the immigration of FMGs called for application of the same graduate medical education qualifying examinations to all.

The report said:

"This country should not depend for its supply of physicians to any significant extent on the immigration of FMGs or on the training of its own citizens in foreign medical schools." If this results in a projected shortfall of supply, "appropriate measures including adequate funding must be taken to enlarge the student body (in domestic schools) accordingly."

The AAMC noted that FMGs are approaching 20 per cent of all physicians here and one-third of all current internship and residency training posts are filled by them. The foreign-trained physicians "perform at a lower level" in objective-type examinations, and "it is generally acknowledged, though not proven, that the medical care rendered by some FMGs is of poorer quality . . . ," the report charged.

There is no evidence that FMGs either concentrate more on primary care or seek out shortage areas, according to the AAMC. Rather, in the aggregate, the FMGs follow about the same pattern in this regard as domestic graduates.

The report said special licensure provisions for FMGs in many state public institutions "suggests that much health care delivery in the public sector depends on physicians not fully qualified but willing to accept working conditions and income levels qualified physicians will not accept."

"The present system of accepting FMGs into the United States and incorporating them into our medical education and care system has created a category of second-class physicians. From an educational and ethical point of view, this is undesirable," the report said.

A decrease in FMGs would require new methods to ensure patient care services in many hospitals, the AAMC conceded, suggesting that other health care personnel be trained to perform some of these functions under the supervision of physicians.

The task force said it found no significant difference in the qualifications of FMGs who are American citizens who have gone abroad for their training and foreigners.

SMA Meeting Set for Atlanta

More than 6,000 physicians and paramedical personnel are expected to gather in Atlanta Nov. 17-20 for the 68th Annual Scientific Meeting of the Southern Medical Association (SMA).

The annual meeting features scientific sessions of 21 medical specialties from allergy to urology. Section work is augmented by general sessions, joint sessions, special symposia, scientific closed circuit television programs featuring surgical procedures and demonstrations live from a local hospital, live teaching demonstrations at the site of the meeting, postgraduate courses, learning center with experts in chosen fields, meetings of conjoint societies, and scientific and technical exhibits.

Commenting on this year's meeting, Dr. Wood W. Lovell, chairman of arrangements, said that every effort was being made to assure those who attend that it would be the most extensive scientific session in SMA's history. "Some of the most distinguished physicians in the nation will be participating in the excellent four-day program we have planned," he said.

Dr. Lovell said that all facets of medicine will be covered during the Atlanta meeting which is open to all physicians including residents and interns, medical students, nurses, technicians and other paramedical personnel.

Officers of SMA are Drs. George J. Carroll, Suffolk, Va., president; Andrew M. Moore, Lexington, Ky., president-elect; G. Gordon McHardy, New Orleans, La., first vice president; Harris D. Riley, Jr., Oklahoma City, Okla., editor of the *Southern Medical Journal;* and R. H. Kampmeier, Nashville, Tenn., editor of *Southern Medicine;* and Mr. Robert F. Butts, Birmingham, Ala., executive director.

More than 200 scientific and technical exhibits

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Proctology Seminar Set for Montreal

The 27th Annual Congress and Teaching Seminar of the International Academy of Proctology will be held at the Hotel Le Chateau Champlain, Montreal, Canada, May 10-16, 1975. Dr. Daniel D. Thomas of Gary, Indiana, president of the academy, will preside.

Scientific Sessions are scheduled for May 12-15, under the direction of Dr. Alvin D. Yasuna, Program Chairman. All physicians are invited to attend the scientific sessions at which time physicians from various parts of the world are scheduled to present scientific papers.

Full information may be obtained by writing directly to the Executive Offices, 147-41 Sanford Avenue, Flushing, N. Y. 11355.

ACP Studies Clinical Medicine In Los Angeles

The American College of Physicians (ACP) will sponsor a five-day postgraduate course entitled "Advances in Diagnosis and Treatment in Clinical Medicine" on Dec. 2-6, 1974, in Los Angeles, Calif. The course, held in conjunction with the University of California School of Medicine and Harbor General Hospital in Torrence, Calif., will take place at the Los Angeles Marriott Hotel.

The postgraduate session is one of 40 to be sponsored by the ACP in the United States and Canada during the 1974-75 academic year. Their purpose is to give specialists in internal medicine and related fields an opportunity to review basic information and to find out what is new in a particular area of interest.

The course is planned to provide a comprehensive review of recent advances in clinical medicine. The format will include presentations followed by question and answer periods. In addition, there will be workshops and luncheons incorporated into the course.

Director of the Los Angeles postgraduate course is Dr. J. Michael Criley of the UCLA School of Medicine, Harbor General Hospital Campus.

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ORIGINAL PAPERS

Upper Gastrointestinal Bleeding

MARCEL PATTERSON, M.D.
Galveston, Texas

The author reviews the problem of gastrointestinal bleeding with emphasis on answering three questions: How much has the patient bled? What is the bleeding site? And will the bleeding continue? He discusses each question in detail to aid physicians in the management of these patients.

GASTROINTESTINAL bleeding appears to the physician as an acute problem, either primary or recurrent, or chronic where symptoms of anemia may dominate the clinical picture. Although the problems are similar: to define the site of bleeding and control it; our approach varies with the situation. Thus, the physician called to care for a patient with a massive gastrointestinal bleed tries to answer three questions: How much has the patient bled? What is the bleeding site? Will bleeding continue? Only the second question can be answered accurately in most instances, but we make attempts to answer the other questions to guide our therapy.

How much has the patient bled?

Human beings react unpredictably to blood loss. Experimentally, 500 to 1200 ml of blood drawn as rapidly as possible produced syncope but some patients fainted after 500 ml and in others, no symptoms appeared until 1200 ml was drawn.[1] All of us have seen patients faint during a venipuncture. Syncope does not tell us the amount of blood loss, although mortality rates are higher with those who faint with their bleeds. The other well known symptoms accompanying shock, i.e., dizziness, faintness, nausea, apprehension, can occur with equal frequency with anxiety.

But, the patient says he vomited blood. We must remind ourselves that not everything appearing red is blood. For example, red wine, beets, chili, spaghetti sauce, "Bloody Marys," and just plain tomato juice can look like blood when vomited. Turnip greens and spinach have been confused with coffee ground material.

Not everything appearing black in the stool is blood. Many proprietary preparations for digestive symptoms contain bismuth. Patients with gastrointestinal complaints can take these in copious amounts, and have dark stools. Similarly, iron, chocolate, licorice, greens, and even bromsulphalein dye in the stool have all been confused with blood.[2]

If you are not sure whether bleeding has occurred, check the stool for occult blood and irrigate the stomach for blood. Every seasoned physician can recall the patient admitted for gastrointestinal bleeding who with observation did not appear to have bled at all.

Estimates of the amount of blood seen or passed by the patient or family seem quite unreliable. The dilution of blood with gastric content, or mixed in the water of a toilet bowl, can give an erroneous impression of the amount lost. Dr. John Galambos of Emory reported an interesting experiment done in

From the Department of Medicine, University of Texas Medical Branch, Galveston, Tex.
Presented before the Section on Medicine, Mississippi State Medical Association, Biloxi, May 8, 1974.

his hospital.[3] Various amounts of blood were poured into emesis basins, bed pans and on sheets, then nurses, medical students, and house staff were asked to estimate the amounts present. Among these trained personnel, the guesses were so diverse as to be useless.

Gross melena usually reflects upper gastrointestinal bleeding in patients who bleed so profusely that the stool appears grossly bloody. Sometimes we are misled to consider the lower gastrointestinal tract first.

A tarry stool means blood loss of at least 50 to 100 ml but nothing can be said about how much more blood it contains.[4, 5] One or two liters of blood introduced into the stomach produced tarry stools in 4 to 20 hours that remained black from 1 to 5 days. Occult blood was detected from 3 to 10 days after the ingestion of 75 to 250 ml of blood and as long as 12 days after the ingestion of two liters.[5]

The cardiovascular response is the best guide to the amount of blood loss although, as we know, the patient's emotional response to the situation influences it significantly. Unfortunately, we cannot assume that a stable pulse or blood pressure means slight blood loss. A pulse between 80 to 120 indicates mild to moderate loss; one greater than 120, ominous blood loss. We appreciate the importance of a falling blood pressure but a stable blood pressure should be checked for its response to posture. Green and Methany[6] observed that if one tilts the bleeding patient's head and body to 75° for 3 minutes, and the pulse rate increased 30 per minute, or syncope occurred, the bleed was severe. If the pulse increased less than 25 per cent and syncope did not occur, the bleeding was slight or well compensated. Shock on admission indicates severe hemorrhage; its gravity depends upon its duration.

Hyperperistalsis suggests active bleeding since blood irritates the gastrointestinal tract. A quieter abdomen with an upper gastrointestinal bleed is a good sign, although absolute quiet or high pitched tinkles can mean perforation or obstruction or infarction.

Hemoglobin reaches its maximal dilution on an average of 3 to 90 hours.[1] Thus, a falling hemoglobin can mean continued bleeding but may reflect hemodilution. Hemoglobin, hematocrit, and red cell counts do not reflect accurately the amount lost in a bleeding episode until 72 hours pass. It seems pointless to check these values more often than every 12 hours. In general, an initial hematocrit of 30 to 35 indicates a serious bleed, but as Spiro writes, "Over-reliance on the hematocrit values during the first 72 hours of treatment is probably the most common error in the management of gastrointestinal bleeding."[7]

Commonly the white count rises in these patients to 10,000 and sometimes as high as 25,000. Leukocytosis occurs from severe bleeding whatever its

TABLE I

QUESTIONS OF VALUE IN HISTORY TAKING OF THE PATIENT WITH UPPER GASTROINTESTINAL BLEEDING

1. What medication has the patient been taking?
2. Does the patient have a known gastrointestinal disease?
3. Does the patient drink alcohol? Has he been drinking lately?
4. Was the episode of bleeding preceded by severe retching?
5. Have there been any recent weight loss, anorexia, or abdominal pain?
6. Does the patient have other medical diseases known to be associated with a high frequency of ulcer, or gastrointestinal lesions?
7. Does the patient have a history of nosebleed, purpura, or bleeding episodes from other sources?
8. Is there a family history of ulcer, polyps, or telangiectasia?

TABLE II

DIAGNOSTIC SKIN LESIONS IN ASSOCIATION WITH GASTROINTESTINAL HEMORRHAGES

Hereditary
- Osler-Weber-Rendu (hemorrhagic telangiectasia)
- Blue rubber-bleb nevus (cavernous angiomas)
- Polypoid disorders i.e., Gardner's syndrome (epidermal tumors and colon polyps), Peutz-Jeghers syndrome (brown lip and finger pigment and intestinal polyps)
- Pseudoxanthoma elasticum
- Neurofibromatosis
- Ehler-Danlos syndrome (joint and skin hyperextensibility and gut friability)

Acquired
- Scurvy
- Kaposi's sarcoma
- Malignant atrophic papulosis (Degos disease)
- Calcinosis, Raynauds, sclerodactyly and telangiectasis (CRST) syndrome
- Primary systemic amyloidosis
- Hematologic disease i.e., Schonlein-Henoch purpura, Polycythemia vera, Hodgkin's granuloma, Pernicious anemia

Skin lesions with gastrointestinal malignancy, i.e., carcinoid syndrome, acanthosis nigricans, skin metastases.

From Samitz, H. A.: Hospital Med., p. 74-92, March-April, 1971.

source. Fever appears in over 75 per cent of bleeding ulcer patients within the first 24 hours and may last from a few days to a week.[8] The degree of fever relates to the severity of the bleed but did not occur when blood was fed experimentally. It does not require the use of antibiotics.

Azotemia occurs after gastrointestinal bleeds, probably from the breakdown of blood proteins in the gastrointestinal tract. In some patients, impaired renal function and reduced blood flow to the kidney contribute to the elevated blood urea nitrogen. The rise usually appears within a few hours. It reaches its maximum in 24 to 48 hours and returns to normal on the third or fourth day.[9] A blood urea nitrogen greater than 75 to 100 mg. per cent signifies a grave prognosis but fatal hematemesis has occurred in the presence of normal levels. Ordinarily, bleeding from the terminal ileum or from the colon does not produce azotemia,[10] a point that may be of diagnostic importance in locating the bleeding site. Furthermore, the serum creatinine does not rise from blood in the gastrointestinal tract.

What is the bleeding site?

Several years ago, Palmer[11] demonstrated how often our clinical impression in acute gastrointestinal bleeds was wrong. He urged us to a more "vigorous diagnostic approach";[12] to look for a bleeding lesion shortly after we see the patient. Now, the evidence seems conclusive that endoscopy will often answer the question, "what is the bleeding site?" Unfortunately, there are places where neither instruments nor endoscopists are available and we can still learn from a careful history and physical examination.

Patients brought to us in a state of shock, or on the verge of shock, present the most difficulty. Here, the urgency of the situation makes us hurry our history taking and rush through the physical examination. We can expect that our diagnostic skills will be blunted and our errors greater.

Where feasible, certain areas in the medical history should be explored. Table I lists questions that may give hints to a diagnosis.

Salicylates, reserpine, phenylbutazone, as well as adrenal steroids, have been incriminated as ulcerogenic. Salicylates, particularly aspirin, produce gastritis and when combined with alcohol can damage gastric mucosa even more. Anticoagulants produce bleeding from a variety of lesions, some quite minor.

Ulcer patients who bleed once are the ones most likely to bleed again and again, even after ulcer surgery.[13] The patient, from our point of view, who bleeds suddenly while under treatment or observation with a known gastrointestinal disease presents a lesser diagnostic problem; since the odds are that he bleeds from a lesion we know about, but you do recall the patient who bled from the unexpected and one cannot carry the assumption too far. Finally, a recent or past examination that included a survey of the gastrointestinal tract may hint a diagnosis.

TABLE III

AN OUTLINE FOR THE MANAGEMENT OF UPPER GASTROINTESTINAL BLEEDING

A. Has bleeding *really* occurred?
 - Check stool for blood
 - Aspirate stomach, if in doubt

B. Draw blood for
 - Complete blood count
 - Platelets
 - Prothrombin
 - Blood urea nitrogen
 - Creatinine
 - Type and cross match
 - Electrolytes
 - Bilirubin
 - Glucose
 - Serum protein electrophoresis
 - Partial thromboplastin

C. Start an intravenous infusion
 - (It may be more difficult if patient goes into shock)
 - Get a routine urinalysis

D. Monitor the urine output

E. Transfuse any patient with
 - Pulse 120/minute
 - Initial hematocrit ± 30
 - 35 if patient 50 or older
 - 25 if patient younger

F. Consider central venous pressure monitoring in the
 1. aged
 2. severe bleeder

G. Sedate the patient with
 - Sodium phenobarbital 120 mgm every 4-6 hours

H. Avoid antispasmotics
 - Where liver disease obvious or expected give
 - 10 mgm vit. K parenterally daily
 - Transfuse with fresh blood (7 days old)
 - Consider fibrinogenemia thrombocytopenia

I. Take an electrocardiogram and repeat in 12 hours
 - (1.7 per cent of adults with gastrointestinal bleeds have an acute myocardial infarction)

J. Local hypothermia—ice water lavage
 - Use large tube

K. *Diagnostic Studies:*
 1. Emergency endoscopy
 2. X-ray—acute barium meal
 3. Visceral angiography

L. *Hourly feeding alternate antacids*
 - Around clock
 - If patient not vomiting

Erosive gastritis probably causes more gastrointestinal bleeds in this country than any other lesion, although only recently appreciated. Coupled with bleeds from esophageal varices as a complication of cirrhosis, often alcohol induced, these two conditions will produce over a third of the cases of gastrointestinal bleeding in the urban medical center.[14, 15]

But how does one get a straight answer about the amount of alcohol a patient consumes? Sometimes families give truer answers, sometimes the lack of family or friends tells even more.

Severe retching preceding hematemesis suggests linear tears in the esophagus (Mallory-Weiss syndrome). Anorexia, weight loss and chronic abdominal pain suggest malignancy or large penetrating gastric ulcers, although massive hematemesis is not common with cancer.

Some medical diseases associated with an increased incidence of peptic ulcer or gastrointestinal lesions are polycythemia, emphysema, uremia, amyloid, hyperparathyroidism. Acute trauma such as burns and head injuries evoke hemorrhagic gastritis or ulcers and may exacerbate dormant peptic ulcer.

A past history of severe bleeds from the nose, minor trauma or surgery, suggest blood dyscrasias, telangiectasias or covert liver disease. A family history of ulcer, polyps, or bleeding may suggest a diagnosis.

Consider the yield from a careful physical examination. (See Table II.) In the nose, on the lips, or buccal mucosa and tongue, one may find telangiectasia (Osler-Weber-Rendu) or the brown pigment of the Peutz-Jegher syndrome (multiple intestinal polyps). Is there alcohol on the breath? Is the breath uremic? Is there evidence of amyloid disease, i.e., hypertrophy of the gums or tongue, swelling of the parotid or lacrimal glands? Look in the eyes. Are there evidences of hypertensive retinopathy or the peculiar angioid streaks of pseudoxanthoma elasticum? Papilledema in association with a head injury or brain tumor might be the first clue to a stress ulcer. Are there nodes in the neck to suggest lymphomas? Are there supraclavicular nodes suggestive of metastasis from an intra-abdominal malignancy? Are there spider angiomata or other stigma of liver disease? Is there an aortic murmur or bruit in the chest, neck or abdomen? Unexplained gastrointestinal hemorrhage arises in association with aortic stenosis. Occasionally aneurysms leak into the gastrointestinal tract. Prominent abdominal veins, an enlarged liver, or a palpable spleen suggest cirrhosis. An epigastric mass suggests a tumor, if it pulsates an aneurysm. Is there a succussion splash suggestive of pyloric obstruction? Are the kidneys felt? Patients with polycystic disease die from uremia and gastrointestinal bleeds. Are there hemorrhoids or a Blumer's shelf? A rectal examination provides us with a gross look at the stool, as well as some material to check for blood. Thus, a careful physical examination may provide much useful information in these patients.

Routinely we get a complete blood count but a platelet count, prothrombin time and a partial thromboplastin, as well as bleeding and clotting time and clot retraction should be included. The routine urinalysis may suggest a collagen disease and a check for Bence-Jones protein might reveal occult multiple myeloma. An abnormal bromsulphalein may be our first indication of liver disease. A serum protein and protein electrophoresis may show paraproteinemia. Table III lists the blood studies recommended for gastrointestinal bleeders.

The development of flexible fiberoptic instruments has revolutionized the field of endoscopy. These instruments pass with relative ease. Findings can be photographed and verified with biopsies. Premedication with Meperidine, 50 to 75 mg. I.M., followed by intravenous diazepam to the point of slurred speech and drowziness results in many patients having complete amnesia and few really object to the examination.[16] The exception has been the alcoholic, particularly the partially intoxicated patient or the one suffering with delirium tremens. Emergency endoscopy increases the yield of diagnosis but unless one contemplates immediate surgery or has trained assistants on a 24 hour basis, there is little to be gained by struggling with the alcoholic or the uncooperative patient in the middle of the night. Furthermore, in this situation, the damage to expensive instruments and the need for duplicate instruments while they are being repaired can make the maintenance cost untenable.

The stomach must be cleansed with ice water before attempting the examination, since a stomach full of blood and food cannot be inspected. To accomplish this, we need a large tube (Fr. #30 [10mm] Ewald) with holes big enough to remove good sized particles. One may see more with less patient trauma if the examination is done when the patient's condition is stable and under circumstances more conducive to a careful examination, that is, if the patient has fasted several hours, has had repeated lavages with ice water and is less anxious. Endoscopy within hours of an acute bleed will make a diagnosis of a bleeding site in over 80 per cent of patients.[14]

Physicians will continue to rely heavily on the radiologist for making a diagnosis in gastrointestinal bleeding. It is well to be aware of the limitations of the examination in this type of patient. When we analyzed our experience with 110 cases whose gastrointestinal bleeds were fatal,[17] we found 33 patients with emergency or recent x-ray examinations of the gastrointestinal tract. Eleven of these were patients with duodenal ulcers, in 6 the ulcers were recognized, but in 5 they were not. Nine patients had esophageal varices, in 5 the varices were recognized, but in 4 they were not. Pyloric ulcers in 2 patients were missed. Usually, gastric ulcers and cancers were recognized, although one large cancer was read as blood clots in the stomach. If a lesion was seen, usually it was the source of the bleed but negative findings exclude nothing and acute superficial lesions, such as esophagitis or gastritis, cannot be diagnosed at all.

It makes sense to do a follow-through of the small bowel in the bleeding patient where the esophagus, stomach, and duodenum appear normal. Radiologists perform better when we discuss our diagnostic problems with them; without an alert, they are not

TABLE IV

LESS COMMON AND RARE CAUSES OF GASTROINTESTINAL BLEEDING

- Lesions of Esophagus
 - Benign and malignant tumors including metastases
 - Esophagitis (not associated with hiatus hernia)
 - Mallory-Weiss syndrome (linear tears from retching)
 - Mucosal prolapse of stomach into esophagus
- Lesions of Stomach
 - Benign and malignant tumors including metastases
 - Foreign bodies
 - Menetrier's disease (hypertrophic gastritis)
- Lesions of the Duodenum
 - Hemorrhagic duodenitis
 - Benign and malignant tumors including metastases
 - Post bulbar ulcers
 - Carcinoma of the pancreas
 - Carcinoma of ampulla of vater
- Lesions of the small bowel
 - Benign and malignant tumors including metastases
 - Solitary ulcers
 - Inflammatory bowel disease
 - Meckel's diverticulum with peptic ulcer
 - Radiation enteritis
 - Wagner's granulomatosis
 - Strongyloidosis
 - Intussusception
- Lesions of the Colon
 - Benign and malignant tumors including metastases
 - Colitis (idiopathic, amebic, Crohn's, radiation and ischemic)
 - Volvulus
- Lesions of Liver and Biliary Tract
 - Hemobilia (from trauma)
 - Erosions from gallstones
 - Severe acute hepatocellular disease
 - Hepatocarcinoma
- Lesions of Pancreas
 - Acute and chronic relapsing pancreatitis
 - Pancreatic cyst
 - Pancreatic carcinoma
 - Aberrant pancreas
- Blood dyscrasias
 - Quantitative and qualitative platelet deficiencies
 - Hemophilia
 - Von Willebrand's disease
 - Christmas disease
 - Lymphomas and leukemias
 - Multiple myeloma
- Lesions of cardiovascular system
 - Aneurysm
 - Hereditary hemorrhagic telangiectasias
 - Cavernous hemangiomas
 - Phlebectasia
 - Vascular insufficiency syndromes
 - Rupture of aortic aneurysm graft
 - Valvular heart disease (particularly aortic)
- Trauma
- Postoperative hemorrhage
- Systemic diseases
 - Periarteritis nodosa
 - Scleroderma
 - Pseudoxanthoma elasticum
 - Amyloidosis
 - Sarcoid
 - Uremia
- Drugs
 - Corticosteroids
 - Reserpine
 - Phenylbutazone
 - Tolbutamide
 - Anticoagulants
 - Hypoprothrombinemia from antibiotics
 - Cancer chemotherapy agents
- Factitial
 - Ingested blood
 - Self-induced lesions of nasopharynx
 - Skin

Modified from: Clinical Pathological Conference. Patient With Repeated Gastrointestinal Hemorrhages. Mayo Clinic Proc. 39:452-465, June 1964.

likely to find a Meckel's diverticulum or other lesion of the small bowel.

Other methods used to find bleeding sites are: intubation with a Miller-Abbott tube and periodic aspiration of the tube for blood as it traverses the bowel, and the passing of a beaded string into the gut and checking it for staining with blood or intravenously administered[18] fluorescein. In my experience, these methods have been time consuming and disappointing. In one study,[19] 40 per cent of 15 human volunteers gave a positive test for blood with a string. Now, visceral angiography would seem a more logical step to take in bleeding of obscure etiology.[20] Unfortunately, the procedure has to be done first, otherwise an intestinal tract filled with barium will cloud the findings and this seems too drastic a procedure for an initial diagnostic step in all bleeders. Obviously, bleeding must be active at the time of the examination for visualization of the bleeding site to occur, at least greater than .5 ml per minute, and one should not overlook the inferior mesenteric artery if the filled celiac does not give an answer. We use this procedure in the patient who has had intermittent bleeding from a unknown cause, but an occasional emergency situation makes it desirable to start with this examination.[21]

Occlusion of the vascular supply of the intestine, as well as poor perfusion, can produce necrosis of the bowel and bleeding.[22, 23] It should be suspected in the older debilitated patient with severe arteriosclerosis, in the patient with congesive heart failure, in the patient with atrial fibrillation, or following a period of prolonged shock or severe stress from a variety of causes. Often the onset is dramatic and the clinical picture may be that of an acute abdomen. At other times, the clinical picture is quite vague and not distinctive. "One of the most characteristic findings with gut ischemia is the lack of significant abdominal abnormalities even when the pain is unbearable. An early positive physical sign is severe abdominal distension occurring even when peristalsis is present."[22] Angiography may demonstrate the site of occlusion in about a third of patients, in the remaining two thirds the diagnosis must be presumptive.

TABLE V

WHAT TO MONITOR ON FLOW SHEET

(1) Hourly B.P.—pulse
(2) Temp. (expect elevation)
(3) Hgb. and Hct., WBC
(4) Vomitus
 amount
 frequency
 color
(5) Stools
 amount
 frequency
 color
(6) Peristalsis
(7) Transfusions
 number
 speed
(8) BUN—Creatinine
(9) Electrolytes
(10) Urine output

TABLE VI

WHEN TO OPERATE?

(1) Continuation of pain after bleeding
(2) BUN 100 mgm.
(3) Persistent active peristalsis
(4) Falling B.P.
(5) Persistent tachycardia
(6) 6 pints of blood/24 hours without stabilization
(7) Older patient
(8) Gastric ulcer
(9) Post-bulbar ulcer
(10) Bleeding after stopping

The vast majority of major gastrointestinal bleeds arise from erosive gastritis, peptic ulcer, or bleeding esophageal varices. Table IV lists some unusual and rare causes that have been reported.

Most of us have had the experience of exploring a bleeding patient and finding nothing. We must accept the fact that there are patients who bleed, sometimes copiously, in whom we never define a bleeding site, but as our diagnostic methodology improves, these instances should be fewer, particularly if we can use our diagnostic tools when the patient actively bleeds.

Table III outlines a plan for the management of acute gastrointestinal bleeding. Although arbitrary, it attempts to provide answers for the problems posed; how much has the patient bled? What is the bleeding site?

Will the bleeding stop?

No one can answer this question in the particular patient but the majority of patients do stop. Certain factors seem to be of prognostic value and certainly, the course of the illness needs to be followed on a flow sheet (see Table V). Depending on the underlying disease process one may wish to monitor other findings. For example, bilirubin, enzymes, platelets and prothrombin time should be charted in the patient with liver disease.

The critical question is: Should one operate? This question cannot be answered categorically but Table VI lists the factors that influence the decision toward surgery. In general, bleeding patients are managed better as a combined undertaking of the family doctor or internist and surgeon.

SUMMARY

The problem of gastrointestinal bleeding has been reviewed with emphasis on answering three questions: How much has the patient bled? What is the bleeding site? And will the bleeding continue? The answers to these questions should help the physician in the management of these patients. ★★★

The University of Texas Medical Branch (77550)

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MEETINGS

NATIONAL AND REGIONAL

American Medical Association, Clinical Convention, Nov. 30-Dec. 4, 1974, Portland, Ore. Annual Convention, June 15-19, 1975, Atlantic City, N. J. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association, 68th Annual Scientific Meeting, Nov. 18-21, 1974, Atlanta. SMA, 2601 Highland Ave., Birmingham, Ala. 35205.

Southeastern Surgical Congress, 43rd Annual Assembly, Feb. 17-20, 1975, Hyatt Regency Hotel, Atlanta. Preceded by postgraduate course, "Cancer of the Breast," Feb. 16.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 9-12, 1975, Biloxi. Mrs. Alyce Palmore, Executive Secretary, P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 107th Annual Session, May 5-8, 1975, Biloxi. Charles L. Mathews, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, Third Monday, March, June, September, December. James S. Poole, The Field Clinic, Centreville 39631, Secretary.

Central Medical Society, First Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Max Pharr, B6 Medical Arts Building, 1151 N. State St., Jackson 39201, Secretary.

Claiborne County Medical Society, First Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, P.O. Box 147, Port Gibson 39150, Secretary.

Clarksdale and Six Counties Medical Society, Third Wednesday, April, and First Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, P.O. Box 128, Summer 38957, Secretary.

Coast Counties Medical Society, First Wednesday, January, March, May, September, and November. J. H. Gaddy, 4502 15th St., Gulfport 39501, Secretary.

Delta Medical Society, Second Wednesday, April and October. Walter H. Rose, 122 E. Baker St., Indianola 38751, Secretary.

DeSoto County Medical Society, Third Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Baxter Clinic, Hernando 38632, Secretary.

East Mississippi Medical Society, First Tuesday, February, April, June, October, and December. Reginald P. White, East Mississippi State Hospital, Meridian 39301, Secretary.

Adams County Medical Society, First Tuesday, February, April, June, August, October, and December, Eola Hotel Roof, Natchez. Walter T. Colbert, Jefferson Davis Memorial Hospital, Natchez 39120, Secretary.

North Central District Medical Society, Third Wednesday, March, June, September, and December. Robert B. Townes, 1196 Mound St., Grenada 38901, Secretary.

Northeast Mississippi Medical Society, First Thursday, March, June, September, and December. S. Jay McDuffie, Nettleton 38858, Secretary.

North Mississippi Medical Society, First Thursday, April and October. Cherie Friedman, 1004 Jackson Ave., Oxford 38655, Secretary.

Pearl River County Medical Society, Second Monday, March, June, September, and December. J. C. Griffing, Crosby Memorial Hospital, Picayune 39466, Secretary.

Prairie Medical Society, Second Tuesday, March, June, September, and December. W. C. Welch, P.O. Box 5448, Mississippi State 39762, Secretary.

Singing River Medical Society, Third Monday, January, March, May, July, September, and November. Jeff Hodges, 1365 Market St., Pascagoula 39567, Secretary.

South Central Mississippi Medical Society, Second Tuesday, March, June, September, and December. Julian T. Janes, Jr., 304 Clark, McComb 39648, Secretary.

South Mississippi Medical Society, Second Thursday, March, June, September, and December. Larry J. Hammett, 2601 Mamie St., Hattiesburg 39401, Secretary.

West Mississippi Medical Society, Third Monday, January, March, May, September, October and November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, The Street Clinic, Vicksburg 39180, Secretary.

Current Concepts in the Treatment of Hypertension

STANLEY B. GARBUS, M.D.
New Orleans, Louisiana

THE MEDICAL PROFESSION has only recently awakened to the extent of perhaps the most significant health hazard of the modern age—hypertension! We have finally approached the statistical sledgehammers that were striking us on the head, and heart. We have begun the arduous task of knowing our enemy, before we can beat him.

Any problem that causes over one million deaths a year, as does heart and vascular disease, must be viewed with some awe. If one realizes that hypertension is one of the major risk factors associated with these deaths, and that 30 million people may have high blood pressure, the extent of the "epidemic" begins to become apparent.

Management of this potential group of 30 million is most complex, since diagnoses are certainly varied, heredity and environmental factors differ and since the medical profession is not clear on what specific regimens are best in all cases. Since half of these hypertensives are unaware that they have it, only half of the others are on therapy, and only half again are on adequate therapy, the therapeutic challenge is a monstrous task.

Prior to embarking on this grand endeavor, we must be painfully honest in informing ourselves of the facts becoming available from the most recent work in the field, and of our own comprehension—or lack of it—of the problem and its potential solutions. First, consider whether the blood pressure rise is actually evident and not an artifact. There is no doubt that labile hypertension exists, and whether it is to be considered in the same light as a fixed elevation remains to be thoroughly demonstrated. More than likely, the labile hypertensive will cause similar damage to the cardiovascular and renal systems, but this is merely a matter of degree.

The diagnostic evaluation and work-up of the hypertensive is another great quandary for the practitioner. This may be complex and expensive, and produce no finite results, or be simple and do the same thing. Perhaps, some basic ground rules can be set forth regarding the testing procedure.

The author states that the problem of hypertension affects some 30 million people. He discusses the diagnostic evaluation and work-up of the hypertensive patient; drug therapy; environmental factors; management; and the problem of motivating good patient compliance with prescribed therapy.

Drug therapy for high blood pressure is another pharmacologic maze, threatening to lose us in the claims and counter-claims. The mass of hypertensives must be subdivided in such a way as to afford all physicians the opportunity of understanding the diverse regimens which will have the best chance of success with different patients. Financial considerations for expensive drugs are very real and may color the choice of therapy. In all fairness, drug companies are aware of the problem and are trying to reduce expenses. Pharmacies most often reflect quite a variation in price, even though their cost may be minimal. Physicians not obtaining adequate responses from their patients because of cost might discuss the problem with the pharmacists. Unfilled prescriptions never treat the disease.

Other important aspects of drug therapy concern the open discussion of side effects of the therapy and how this may be managed. Such items as lethargy, orthostatic hypotension, gastrointestinal disturbances, impotence and loss of libido must be understood, identified and overcome if possible. In establishing such a rapport with the patient, the long-term nature of therapy can be established and a more successful outcome can be anticipated.

If the natural history of untreated hypertension is outlined, different facets of management can be

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Presented before the Section on Medicine, Mississippi State Medical Association, Biloxi, May 8, 1974.

inserted at the appropriate places in the scheme in order to break the cycle and attenuate the outcome. No doubt some degree of disease will be predetermined by hereditary factors. This is understood to be multifactorial, difficult to quantitate and serving mostly as a warning for those so affected.

Environmental factors such as diet, salt, exercise, smoking, etc. may have an additive effect, especially with inherited factors leading to the prehypertensive stage from birth to approximately 30 years. It is at this time that increased cardiac output may begin.

Probably between 20 and 40 years of age is the true onset of the observable elements of the disease, including increased peripheral resistance. By the time that the process has become established (30-50 years), atherosclerosis has also begun to inevitably lead to the complications:

1. Cardiac—enlargement, failure, infarction.
2. Aortic—aneurysm, embolism, occlusion
3. Renal—arteriosclerosis, insufficiency and failure (leading to dialysis and transplantation).
4. Cerebral—thrombosis, embolism, hemorrhage.

Thus drugs during the earlier stages might be more directed toward the increased cardiac output and peripheral resistance, while later on, specific management problems would be more concerned with the specific target organ or organs most affected.

Waiting for symptoms to develop before instituting therapy may be like putting out a fire with a thimble. The classical headache, epistaxis, tinnitus and dizziness all occur at almost the same frequency in normotensives as in hypertensives. It is only the well-done blood pressure reading that must serve as the initial guide for further investigation.

Certainly the circumstances of the blood pressure elevation (e.g. sudden onset, post-trauma, paroxysmal nature) and detailed history are helpful. Thorough physical examination including funduscopic, cardiac and careful abdominal exam for renovascular bruits are other mandatory elements of the evaluation. But it is the laboratory evaluation that affords the widest room for individual interpretation based upon the preceding items. The clinical circumstances, age of the patient, reliability, facilities and finances available and the physician's attitude must all be included in any delineation of the problem.

A basic laboratory evaluation might include:

1. blood—BUN, creatinine, sodium, potassium, and cholesterol.
2. urine—urinalysis, urine culture, 24 hour urine for sodium, potassium and creatinine.
3. electrocardiogram—chest x-ray and creatinine clearance.

These should be available to most physicians and offer the best yield for the money invested.

An intermediate evaluation based on some index of suspicion would include, in addition:

1. blood—CBC, electrolytes, calcium, and uric acid.
2. urine—VMA (Metanephrines is better), and 17-keto steroids as indicated.
3. renin—either peripheral or bilateral renal vein renins.

These procedures are becoming more available, and certainly the serum renin concentration or the plasma renin activity has received much notoriety of late, and may indeed be the one most important diagnostic and therapeutic consideration available. This all supposes that plasma renin activity (PRA) will be inexpensive enough and readily available to physicians and hospitals. Renin will be further discussed shortly.

The exhaustive evaluation is really looking for the 10-15 per cent of secondary hypertension which may be suggested by other data. This would include renal disease, renovascular disease, coarctation, primary hyperaldosteronism, Cushing's syndrome or pheochromocytoma. Primary or essential hypertension accounts for the remaining 85-90 per cent of hypertensives. The specific tests in this category include:

1. blood—L.E. preparation, anti-nuclear factor and triiodothyronine.
2. aldosterone—suppression test or levels in urine, plasma and differential adrenal veins.
3. Hypertensive (rapid sequence) intravenous pyelogram.
4. Isotope scans—99 m technesium and 131-I hippuran.
5. Renal arteriogram or aortogram.
6. Renal biopsy.

Suitable doctrines of management are then applied to the specific etiology being diagnosed. The diagnostic plan would separate the secondary causes first, and if none were found, primary hypertension would be presumed and a different guideline would be followed.

Renovascular disease is most often found by rapid sequence IVP, noting a difference in kidney size or function (on the early films). This must be followed by bilateral renal vein renin to assess the functional significance of the lesion. In most a ratio of 1.5:1

with the unaffected (normal) side having a normal renin value would be good evidence for a unilateral renal arterial lesion.[1] This should be seen on renal angiography. Surgery could be considered for such a lesion, preferably an arterial by-pass or graft, but the possibility of unilateral nephrectomy must be anticipated. One would be more likely to consider this therapy in a younger individual with a recent onset of the disease.

If the bilateral renins show a bilateral abnormality by both renin values being elevated, medical treatment is the prime consideration. Bilateral nephrectomy has been done in some resistant cases, but this is usually reserved for those with end-stage renal failure. Appropriate attempts with propranolol, methyldopa or clonidine are especially useful in these cases.

Renal diseases must first be determined by renal functional evaluation with BUN, creatinine, creatinine clearance, microscopic examination of the urine and followed by biopsy. If necessary, specific management of chronic renal failure may be required (e.g. dialysis or transplantation). Therapy in these cases follows the basic outline of Diet-Diuretics-Drugs. Low salt diet of 1-3 grams of sodium/day, and thiazides or furosemide are usually required. Drugs especially useful are methyldopa and propranolol (in normal or high renin states), but minoxidil and clonidine should also be considered.

Propranolol is currently under active investigation for use in hypertension.[2] The rationale for use is that the drug is a beta-adrenergic blocking agent. There may be three potential sites of action:

1. The juxtaglomerular apparatus of the kidney, at the terminal beta-adrenergic nerve endings, where these nerve fibers are thought to be responsible for the release of renin.[3] The fibers terminate in the granule-containing cells of the afferent arteriole, where renin is probably produced or stored. The beta blocking effect here serves to reduce the release of renin into the circulation, making this direct effect extremely valuable in therapy.

2. The effects of beta-adrenergic stimulation to the myocardium are blocked, producing a reduction in cardiac output.[4] This effect complements hydralazine therapy in that the central cardiac stimulatory effects of hydralazine are blocked and the management of the hypertension is enhanced.[5]

3. Some central nervous system blockage of beta-adrenergic stimulation has also been suggested.[6]

Adrenal cortical disease, producing either adenoma (primary hyperaldosteronism) or hyperplasia (pseudoprimary hyperaldosteronism) should be studied first with serum potassium and 24 hour urine sodium and potassium. Next, depending on facilities and finances, either a spironolactone therapeutic trial[7] of 400 mg daily for 4-6 weeks or a salt suppression of aldosterone secretion (using 200-250 mEq of sodium/day) may be initiated. In the latter case, a normal person will suppress aldosterone production below a critical level (18-20 micrograms) while the autonomous gland will not be suppressed, thus giving a persistently high aldosterone level in the blood or urine.

This can then be followed with bilateral adrenal vein catheterization to localize the source, if it is an adenoma, or to show that it is bilateral as in some cases of bilateral cortical hyperplasia. Appropriate surgery must be considered, but spironolactone therapy may be adequate if surgery is difficult to accomplish. Drug therapy with spironolactone in males may be more difficult due to the potential side effect of gynecomastia.

Other miscellaneous etiologies may be specifically managed once they are diagnosed. Two unusual causes of hypertension are very simply remedied by stopping the intake. These are, first, oral contraceptives which may produce elevated blood pressure by increasing the production of angiotensinogen, which is the alpha-2 globulin produced in the liver and acted upon by renin to produce angiotensin. Second, licorice ingestion may raise the blood pressure because it contains glycyrrhizinic acid, which has an aldosterone-like action.

Primary hypertension, diagnosed by exclusion, must be controlled. This concept of control or "adequate" therapy means that degree of therapy that will preclude the development of eventual target organ damage. Most probably this suggests keeping the diastolic blood pressure as close to 90 mm Hg as possible without causing intolerable side effects.

This control should consist of three basic elements.

1. *Diet:* This includes both low-sodium in the range of 1-3 grams of sodium (44-132 mEq) daily, depending on the severity, and weight reduction. Sodium intake in various ethnic groups has been seen to correlate with frequency of hypertension.[8]

2. *Diuretics:* Either spironolactone, thiazide, or the combination of both are acceptable for the uncomplicated case, although furosemide is often necessary to obtain the desired effect of reduction in plasma volume and fluid overload.

3. *Drugs:* Each of the six drugs (methyldopa, propranolol, hydralazine, guanethidine, reserpine

and clonidine) has its specific effects and side effects. Perhaps the simplest scheme can be best seen by the recent recommendation of the American Heart Association and the National High Blood Pressure Education Program. Drug therapy is first begun with either methyldopa, hydralazine, or reserpine—given up to their maximal dosage levels. Then, one of the secondary drugs (methyldopa or hydralazine) are *added* to the first one if needed.

Our clinic uses little reserpine as the first choice, and rarely uses a combination as a first effort. Certainly, these drugs have their place, especially in areas where follow-up visits are difficult. But, if one is to understand the therapeutic process each drug must be carefully chosen for precise reasons and to produce a desired result.

With the recent interest in renin and its involvement with hypertension, it may be useful to consider antihypertensive therapy in the light of the effects of various drugs upon renin activity.[9] Renin inhibitors are: propranolol, clonidine, methyldopa, reserpine, ganglion blockers and guanethidine.

Renin stimulators are: aldosterone antagonists, diuretics and vasodilators (nitroprusside, hydralazine, guancydine and minoxidil).

Renin, in its dual role of diagnostic and therapeutic guide, is fast becoming a most controversial test. Although time does not permit a detailed discussion of its action, there are many review articles which describe renin and its effects in the body.[10, 11, 12] Suffice to say that it can be very useful in many cases.

One essential element that must always be coupled with the renin determination is a measure of the sodium balance in the body, conveniently manifested by the 24 hour urine sodium level. When renin from a group of normal individuals is examined, they are noted to fall within three more or less distinct categories: high, normal and low—in relation to the sodiums.[13]

If the renin is high, one might suspect renovascular disease; if it is low, adrenal cortical mechanisms may be suspected. Since essential hypertensives were noted by Laragh and his group to have either high, normal or low renin, it would appear to be a universally useful procedure.[9] High renin essential hypertensives may respond better to propranolol, while low renin individuals may do better with spironolactone and aldosterone antagonists.

For practical purposes, blood pressure control can be considered in a simplistic manner concerned with cardiac output (CO) and total peripheral resistance (TPR). If the CO is the major problem, this can infer a volume overload or a salt and water problem, which may be managed with diuretics. If the TPR is primarily at fault, renin may be the guilty one and anti-renin therapy such as propranolol would be indicated.

The therapeutic scheme of Dr. Laragh's, based upon this, includes the following course of action:[9]

1. Diuretic (thiazide or spironolactone).
2. If no response, stop diuretic and begin propranolol.
3. If no response, give diuretic with propranolol.
4. If no response, consider other therapy.

Further categorization of plasma renin activity can be seen by the following table from Dr. John Laragh.[9]

Low PRA
Without Aldosteronism
- Low-Renin essential hypertension
- Parenchymal renal disease
- Liddle's syndrome (pseudohyperaldosteronism, abnormal Na reabsorption)
- Iatrogenic:
 - mineralocortoid therapy
 - licorice ingestion (glycyrrhizinic acid)

With Aldosteronism
- Primary
- Pseudoprimary
- Glucocorticoid suppressible

With Mineralcorticoidism
- 11-beta hydroxylase deficiency
- 17-alpha hydroxylase deficiency
- Adrenal carcinoma
- Ectopic ACTH-secreting tumor
- Excess 18-OH desoxycorticosterone

Normal PRA
Without Aldosteronism
- Normal-renin essential hypertension
- Unilateral renal disease
- Bilateral renal vascular or parenchymal disease
- Cushing's syndrome
- Coarctation of the aorta
- Pheochromocytoma

High PRA
With Secondary Aldosteronism
- Malignant or severe hypertension
- Unilateral renal disease with severe hypertension
- Bilateral renal vascular or parenchymal disease
- High-renin essential hypertension
- Renin-secreting kidney tumors
- Iatrogenic: oral contraceptive use.

Moreover, Laragh suggests that patients with low-renin essential hypertension have a lower morbidity from strokes and myocardial infarctions. Although this work is currently being discussed and studied by various investigators, its potential significance cannot be overlooked.[14] In any event, the scheme of categorizing a patient by low, normal or high renin and low, normal or high aldosterone may prove very valuable in the next few years.

CONCLUSION

Management of hypertension has progressed from such early remedies as extract of watermelon and cucumber seeds; mistletoe or garlic; avoidance of red meat; sexual abstinence; cold baths; and cathartics.

Much of the current therapeutic impetus is owed to Dr. Edward Freis' work with the VA cooperative study revealing a marked reduction in morbidity in a group of treated patients as compared to a control group.[15]

The most active problem now facing physicians in the management of hypertension is the expertise to motivate good patient compliance with prescribed therapy. Patients discontinue treatment for a variety of reasons. They may be unaware of the risk, not have symptoms, have inadequate follow-up, find the drugs too expensive, or they may be unaware of the side effects. Some helpful hints to improve compliance are: try to give fewer pills; discuss the side effects; indicate the long-term nature of the therapy; have the patient take his blood pressure at home; establish a good rapport with the patient.

Only in this manner can we overcome the medical challenge which suggests that over 20 million people are in need of appropriate antihypertensive therapy in this country.

In closing, let us recall by these overpowering statistics that "even a little is too much." ★★★

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Radiologic Seminar CXXXXV: Nitrofurantoin Lung Disease

EDWARD L. GIEGER, JR., M.D.
Jackson, Mississippi

NITROFURANTOIN is an antibiotic used in treatment of genitourinary tract infections. Since its introduction in 1953, various side effects have been reported, one of which is an acute pulmonary allergic reaction. Clinically, this reaction may simulate bacterial pneumonia, pulmonary edema, pulmonary embolism, or myocardial infarction.

CASE REPORT

A 57-year-old woman had been treated for one week with Macrodantin (nitrofurantoin macrocrystals) for cystitis. After five days of therapy, the patient began having chills, fever, and cough. Fine, moist rales were heard throughout both lungs, more prominent in the lung bases. Admission chest radiograph (see Figure 1) demonstrates a diffuse interstitial infiltrate throughout both lungs. The drug was discontinued and symptoms improved within 24 hours. A chest radiograph obtained three days after admission (see Figure 2) demonstrates essentially complete clearing of the pulmonary infiltrate.

With some variations, reported cases of nitrofurantoin lung disease all follow a similar pattern. Onset of symptoms usually occurs five to seven days following administration of nitrofurantoin but may begin within several hours of drug ingestion. Symptoms are chills, fever, cough, dyspnea, and malaise. Scattered rales are present over both lung bases. Eosinophilia is usually present in the acute phase.

Radiographic findings are those of an interstitial infiltrate, predominantly basilar, with a somewhat coarse, reticular pattern. Small pleural effusions are frequently present. Alveolar consolidation is usually not seen. The pulmonary infiltrate will clear within several days after the drug is withdrawn.

A chronic form of the disease has been reported in persons on long-term nitrofurantoin therapy. There appears to be no relationship to the acute form just described. Cough and dyspnea begin insidiously approximately six months to six years fol-

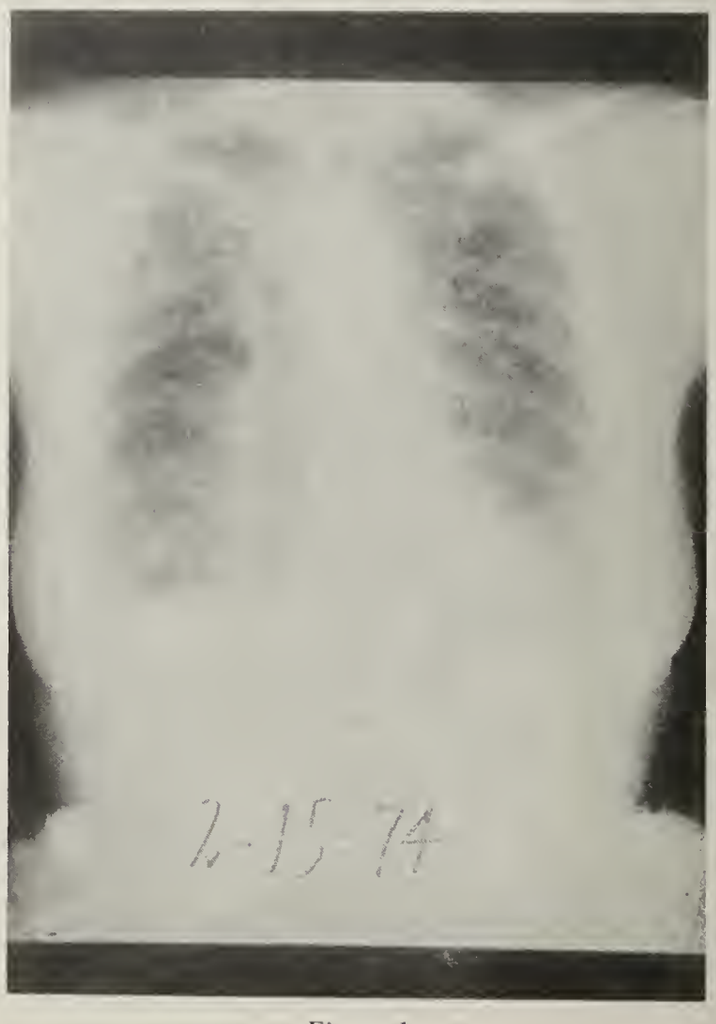


Figure 1

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, St. Dominic—Jackson Memorial Hospital, Jackson, Miss.



Figure 2

lowing institution of therapy. Fever, pleural effusion and eosinophilia are absent. Chest radiograph shows a diffuse interstitial fibrotic pattern which is partially reversible when the drug is withdrawn and corticosteroid therapy is instituted.

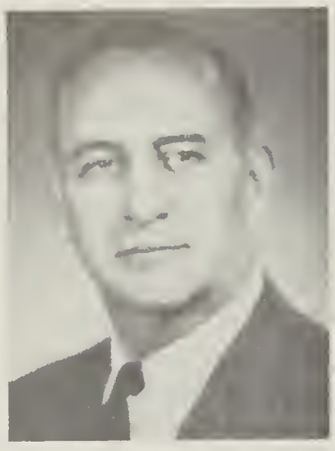
The pathogenesis of the pulmonary changes in acute nitrofurantoin lung disease is thought to be an allergic hypersensitivity reaction which alters capillary permeability. An allergic transudate causes interstitial edema which clears rapidly following withdrawal of the drug. An interstitial pneumonitis would not tend to clear as rapidly or as completely.

The diagnosis of nitrofurantoin lung disease requires a high index of suspicion and should be considered in any patient receiving nitrofurantoin who develops a basilar pulmonary infiltrate, cough, fever, and dyspnea without other evidence of congestive heart failure. Clearing of the infiltrate within two days following discontinuance of the drug supports the diagnosis. ★★★

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The President Speaking

"The Great Obsession"

J. T. DAVIS, M.D.
Corinth, Mississippi

FOR THOSE OF YOU who worry and fret about collections, accounts receivable, "shoppers" and "dead beats" the recent story published in the AMA UPDATE may contribute immensely toward restoring one's faith in the behavior of the human race.

The story relates that a well established physician in the Midwest has been giving his patients the "slip." That slip which is enclosed with each statement of account mailed to his patients reads like this:

TO ALL MY PATIENTS

"My fee schedule is based upon standard medical practice in this area.

However, for retired persons on limited pensions, or any other whose financial circumstances are difficult due to extensive illness, unemployment or for other reasons, I will reduce my fees.

Under these circumstances I suggest a 25 per cent reduction, but more or less may be appropriate to your situation. No discussion is necessary—simply write the amount of reduction you choose on the statement with your remittance."

Richard R. Grayson, M.D.

To prove that such an honor system does work, Dr. Grayson says "surprisingly few patients, possibly 2-3 per cent, take advantage of this offer to reduce their doctor bill."

With the approaching season of thanksgiving in this world of cynicism, selfishness and pessimism, comes this story, refreshing as the cool waters from the oasis in the middle of the desert. It is apparent that the Golden Rule is not dead but just in hiding and may be rediscovered or found by he who may not have lost all compassion for those less fortunate in the struggle for existence.

The intangible rewards of giving are many. Those who view the act of giving as a duty filled with public acclaim, rather than to satisfy an inward desire, should remember that old adage, "A gift without the giver is bare."

In the same sense it would seem paradoxical that one should receive the blessings and satisfaction of charitable giving of monies gleaned from a strong dollar-oriented medical practice. Rather, Dr. Grayson has chosen to contribute his efforts and services to those close to him whom he knows best—his patients—without fanfare or public recognition other than the gratitude of those in need whom he has helped.

Obviously, Dr. Grayson's actions reflect an unusual humanitarian beneficence in his search for the "Great Obsession" of human satisfaction.

Would that we had more like him not just in the medical profession, but throughout the world. ★★★

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EDITORIALS

Carcinoma of the Breast: Fountain of Confusion

In the late 1890's, Dr. Halstead of Baltimore and Dr. Willie Meyer of New York described the standard or "classical" radical mastectomy for carcinoma of the breast. This consisted of an en bloc removal of the breast, axillary nodes, and both pectoral muscles. Most of their patients were seen in the late stages of the disease with large bulky or ulcerated tumors with axillary metastasis. Thus, only by a radical procedure could all involved tissue be removed.

In the past 20 years, due to the educational efforts of the American Cancer Society and others, patients are now being seen in an earlier stage of the disease, many with small lesions without axillary metastasis. The conservative approach to cancer of the breast is being extolled not only by some surgeons but also in the lay press. Many patients now insist that they be given a choice of operations, or may even demand operations causing minimal loss of breast tissue.

Thus, the female breast becomes a fountain of confusion, with conservative operations being advocated such as lumpectomy, partial mastectomy, simple mastectomy, and modified radical mastectomy for the treatment of cancer. To the older surgeon, long steeped in the tradition that the only treatment for cancer of the breast is a radical mastectomy, a critical re-evaluation seems in order.

CONSERVATIVE SURGICAL APPROACH

The champions of the conservative surgical approach to carcinoma of the breast are Dr. George Crile and Dr. Robert Hermann of the Cleveland Clinic. They advocate partial mastectomy for small tumors less than two centimeters in size which are not of the multicentric type and without axillary metastasis, especially when the patient wants the breast preserved. Their reasoning is that in the absence of positive nodes on intraoperative staging there is an immunological benefit from leaving the axillary nodes. Their results with partial mastectomy have shown about a 5 per cent recurrence in the same breast, which is the same as the occurrence of new carcinoma in the opposite breast. If nodes in the axilla later become positive, they are removed either by axillary dissection or are treated by radiation therapy. They do a simple mastectomy without axillary dissection if no nodes are found involved by intraoperative staging and if the tumor is central in the breast tissue or of the multicentric type. Most of their operations consist of modified radical mastectomy, which is done for large or central breast lesions where the axillary nodes are involved either by clinical examination or by intraoperative staging of nodes and biopsy at the time of surgery. Their five-year survival rate is comparable with that achieved by radical mastectomy.

RADICAL SURGICAL APPROACH

Dr. Jerome Urban of Memorial Hospital in New York advocates a more aggressive approach to breast cancer. Since most cancers of the breast are multicentric, the minimal operation should be a total mastectomy. He does a classical radical mastectomy in patients with outer-half lesions with low risk of internal mammary disease and advises extended radical mastectomy with internal mammary dissection in patients with inner quadrant lesions where the risk of internal mammary disease is greater. A modified radical mastectomy is done only in patients who are poor surgical risks. In these patients with medial quadrant lesions, the mediastinum is treated by cobalt therapy.

SUMMARY

Lumpectomy or partial mastectomy is not to be condoned in any patients except those who are extremely poor operative risks or who refuse to have a more radical operation. Due to the multicentric origin of carcinoma of the breast, especially in intraductal or lobular types, removal of only the local lesion is likely to leave other foci of cancer in the breast. There is a trend toward conservatism in that most carcinomas of the breast are now treated by modified radical mastectomy. This consists of a complete mastectomy, together with a thorough axillary dissection. The only difference between a modified radical mastectomy and a classical mastectomy is that the pectoral muscles are left intact. The axillary dissection must be as complete as one performs in a classical operation. A classical radical mastectomy is reserved for those patients who have large tumors which are fixed to the chest wall and are likely to have invasion of the fascia of the pectorial muscles. A radical mastectomy is also done in patients who have palpable axillary metastasis prior to surgery. The extended radical mastectomy, in which the internal mammary chain is resected, should not be done by the occasional operator. There will be less morbidity and almost as good survival by doing a modified radical mastectomy combined with cobalt therapy to the mediastinum.

The final answer as to the best operation for carcinoma of the breast has not yet been found. Continuing studies of the value of immunological destruction of cancer cells by axillary lymph nodes may change the thinking on this subject. At the present time, modified radical mastectomy seems to be the operation of choice in most instances until further information is available in this field.

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NHSC Steps Forward

Successful delivery of general medical care to health manpower shortage areas is one of the tremendous challenges facing the health care field today. Some estimates of the number of these areas run as high as 5,000.

Although no one program can overcome the task of providing health coverage, the National Health Service Corps of the U. S. Public Health Service and organized medicine have taken some commendable steps to provide help to alleviate the most acute areas.

The National Health Service Corps is a federal health manpower deployment program established by the Emergency Health Personnel Act of 1970. The aim of the program is to provide physicians, dentists, and other health personnel to areas of the United States in critical need of health manpower. It is hoped that most will remain in these areas when their enlistment in the corps expires.

Impetus to the program is expected from passage of a bill presently being considered by Congress which would provide federal aid to medical and dental schools that agree to allocate 25 per cent of their classroom space to students volunteering to serve in areas short of physicians and dentists. In return for either civilian or federal service under the NHSC, the students would receive scholarships repayable by service in health manpower shortage areas.

The Mississippi State Medical Association's House of Delegates went on record in support of the NHSC Program in 1971. The American Medical Association has supported NHSC since 1972. The AMA developed a recruitment program called "Project USA" to provide physician replacements for the corps physicians when they are on vacation or are away for other purposes. The AMA is now recruiting "mid-career" physicians for service with the corps.

The NHSC Program is a good example of organized medicine and government taking the right step, in the right direction, at the right time—together.

CHARLES L. MATHEWS
Executive Secretary

Medico-Legal Briefs

LAW VS. MEDICINE: THE COMMUNICATION GAP

Over the past several years the medical and legal professions have witnessed an ever-widening gap developing between the members of both organizations. That conflict exists between doctors and lawyers hardly anyone will deny.

There are many obvious surface irritations that serve to foster the climate of ill-will between doctors and lawyers. The physician gets upset because he feels as if he is taken advantage of in his role as an expert witness. He blames the lawyers for having to sit in a bleak witness room for hours waiting to testify at only a fraction of the customary remuneration paid for his services. He often feels that the lawyers' contingency fee system encourages malpractice suits and that whether he has actually been sued for malpractice or only threatened with suit, the "ambulance-chasing" lawyer is to blame for his troubles.

On the other side of the coin and compounding the problem, the lawyer feels that doctors are professionally selfish and overprotective in their refusal to testify as an expert witness against a fellow physician, and that if by some magnanimous stroke of fate they do agree to testify they submit a statement for services that makes the attorney feel as if he picked the wrong profession.

One of the most obvious shortcomings between the two professions is communication, and perhaps this failure to communicate is due, in a large part, to the vast difference in subject matter in law and in medicine, all of which has resulted in the development of a unique methodology, environment and organization shared by each profession. The subject matter of law is the settlement of disputes between people. Since medicine fundamentally deals with science its methodology is necessarily more precise and exacting than legal methods. Modern medicine is principally the product of the application of the scientific method to the problems of human disease, and like the law, certain premises are available to the physician which will hopefully apply to the patient's case. But after this initial step in the problem solving process, law and medicine go their separate ways. For the physician, diagnosis and treatment proceed together, each hopefully reacting to the other. While the physician works with a set of facts that are constantly changing, he is trained to adapt to such change and adjust his handling of the problem accordingly. On the other hand, the lawyer's facts are almost always fixed and in the past.

The subject matter of law necessarily limits the application of the scientific method. The settlement and avoidance of human conflicts and disputes involves the intricacies of the human frame of mind related to events mostly occurring in the past. Legal method involves value judgments relating to human conduct and the resolution of human disputes involves the application of law to factual situations, including the states of mind of parties to the dispute. On the other extreme, the physician is dealing with present facts mostly of a physical nature with which the instruments of modern science are highly useful. As one can readily see, the law's method of dealing with factual determinations is paltry by comparison. Scientific principles are discovered and tested in the laboratory, while laws are made; hence, there are good laws and bad laws because they are created by men. Their testing ground is not the controlled environment of the laboratory, but that highly complex hodge-podge of human characteristics called society. It is ridiculous to speak of scientific principles in terms of their goodness and badness. If the principle exists then that existence proves itself, and no one can change it, not the Congress by repealing it or the Supreme Court by over-ruling it. By contrast, the lawyer's rules can be amended, repealed or overruled.

The solution of human disputes with these rules is not at all like curing human illness. The lawyer is beset by an exasperating set of variables, not the least of which is another human being who is opposed to what the lawyer's client is trying to do. The problem is further compounded by the fact that this other person goes out and hires his own lawyer to join in the dispute. Just as repugnant to the scientific approach is the fact that in most cases the lawyer engaged in a legal problem must forget his objectivity. The principal method of law for dealing with human disputes is the adversary court trial which is the antithesis of the physician's diagnosis and treatment process. Not only the lawyer's methodology but his canon of ethics requires him to be partisan rather than objective.

Probably nothing is more misunderstood by nonlawyers than the adversary trial system. Perhaps this is due to the fact that medical men work in concert toward the solution of a common problem—curing the patient. Adverseness is unknown. In order to understand the adversary system it is necessary that one recognize it as a method of arriving at or determining the truth. A crude system, yes, but one that has survived for centuries, and though it often fails to disclose the actual truth of the dispute there is at present no better system for determining a working truth that solves conflicts in a peaceful manner. A final judgment in a court trial establishes the official truth and most of society accepts it because there is nothing better available.

From his very first day in law school the lawyer is nurtured in controversy and he graduates into an adversary system where contest, argument and questioning are a way of life. Medical education relies primarily on textbooks, lectures and clinical experience. The medical student learns that the best method of arriving at truth lies not in adversary disputation but in cooperation with his colleagues.

Most rules of law are based on states of mind. Did the person accused of murder act with malice aforethought? Was he sane at the time the act was committed? What did the testator intend when he wrote his will? Did the person accused of negligence act with due care? The adversary system remains the

most precise method for determining such past mental states.

Compounding the misunderstanding of the adversary system is the seeming shallowness of it as viewed by the layman, an appraisal which often appears well-founded when one sees opposing lawyers contending vigorously in the courtroom but slapping each other on the back and laughing outside. Attorneys are not bothered by this since their legal education has conditioned them to accept the adversary system for what it is—an imperfect yet durable creation.

There is a remarkable difference in the decision-making roles of the lawyer and physician. In the diagnosis and treatment process, the physician in charge usually analyzes the facts and determines the course of treatment. Other consulting and attending physicians may be called into the case and some may disagree as to the method of treatment, but the physician in charge ultimately makes the decision. An erroneous medical decision is not corrected by some higher tribunal. The physician is judge, jury and appellate court all in one. By contrast, the lawyer's method subjects his work to the constant scrutiny of other authorities. His every move and action is not only observed but often challenged by the opposing attorney, the judge, the jury and perhaps a chain of appellate courts. It is hard to imagine the physician working under similar circumstances, operating on a patient to the objections of another physician or having his operative method over-ruled after making the incision.

Unilateral decision-making is appropriate in medicine because pathological functions render the final judgment on the problem of disease. In the application of law to a human dispute the adversary system is necessary because human beings render the ultimate judgment. Law is more artificial than natural, all of which has led society to implement a complex system of checks and balances to preserve the judicial process: adverse attorneys to assure that all the facts are exposed and as a check on the activities of each other; the judge to check on the jury and the opposing attorneys and who shares in the decision-making process with the jury; and appellate courts to correct mistakes made in lower courts. The adversary nature of the process is to assure that nothing substantially relevant will be overlooked by the human beings who resolve the dispute.

These are some of the reasons for the interprofessional prejudices that can only be alleviated by better communication and understanding on both sides. No profession has a monopoly on intellect and skill. Each is deserving and very much needed by society and perhaps by understanding the fundamentals of each profession its members will be more adequately prepared to fulfill those needs of society.

William F. Roberts, J.D.
Executive Assistant
MSMA

POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Nov. 4-8, 1974

Hematology-Oncology Intensive Course

University Medical Center, Jackson
Nov. 4-8, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
Francis S. Morrison, M.D., associate professor of medicine and director of division of hematology, the University of Mississippi School of Medicine

Recent advances in oncology as well as the basics of diagnosis and therapy will be presented. Supportive management such as advances in component and problems of infection in immunosuppressed patients will be emphasized. Newer developments in hematology will also be covered.

Nov. 4-8, 1974

Urology Intensive Course

University Medical Center, Jackson
Nov. 4-8, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
W. Lamar Weems, M.D., associate professor of surgery and director of division of urology, the University of Mississippi School of Medicine

The emphasis of this course will be on practical urology as it relates to the nonurologist. The latest concepts and practices in common urologic diseases will be presented.

Nov. 11-15, 1974

CARDIOLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 11-15, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
James R. Galyean, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

The course will familiarize physicians with current concepts in bedside diagnosis of heart disease. Practical points in physical diagnosis and review of the various forms of heart disease will be covered using aids such as pulse tracings, phonocardiograms, electrocardiograms, x-rays, and hemodynamic data in illustration. Participants will round, watch cardiac catheterizations, and enter into team discussions on patient management. Reasons for suggesting or rejecting surgery will be discussed in detail. A cross section of cardiac diagnoses will be reviewed.

Nov. 18-22, 1974

NEPHROLOGY INTENSIVE COURSE

University Medical Center, Jackson
Nov. 18-22, 1974

Sponsored by the University of Mississippi School of Medicine, with support from the Mississippi Regional Medical Program

Coordinator:
John D. Bower, M.D., associate professor of medicine and director of the artificial kidney unit, the University of Mississippi School of Medicine

This clinically oriented course will emphasize the reversible and treatable forms of kidney disease. The management of acute kidney failure and the control of the reversible features of chronic kidney disease will be presented in depth. The management of pyelonephritis, glomerulonephritis, nephrotic syndrome, fluid and electrolyte problems, and acid-base balance will be covered. The participants will become familiar with physiology, pathology, radiology, immunology, urology, transplantation and hemodialysis in clinical nephrology.

FUTURE CALENDAR

Nov. 4-8, 1974
HEMATOLOGY-ONCOLOGY INTENSIVE COURSE

Nov. 4-8
UROLOGY INTENSIVE COURSE

Nov. 11-15
CARDIOLOGY INTENSIVE COURSE

Nov. 18-22
NEPHROLOGY INTENSIVE COURSE

Jan. 27-31, 1975 (Tentative)
EKG INTENSIVE COURSE

Feb. 10-14
UROLOGY INTENSIVE COURSE

Feb. 17-21
ENT INTENSIVE COURSE

Feb. 24-28
PEDIATRIC INTENSIVE COURSE

Mar. 3-7
HEMATOLOGY INTENSIVE COURSE

Mar. 13-15
SURGERY CONFERENCE

April 7-11
PULMONARY MEDICINE INTENSIVE COURSE

April 14-18
NEPHROLOGY INTENSIVE COURSE

April 21-25
RADIOLOGY INTENSIVE COURSE

May 5-8
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

May 19-23
FAMILY PRACTICE REVIEW

All intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, pharmaceutical firms, volunteer health agencies, and private donation. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged for each.

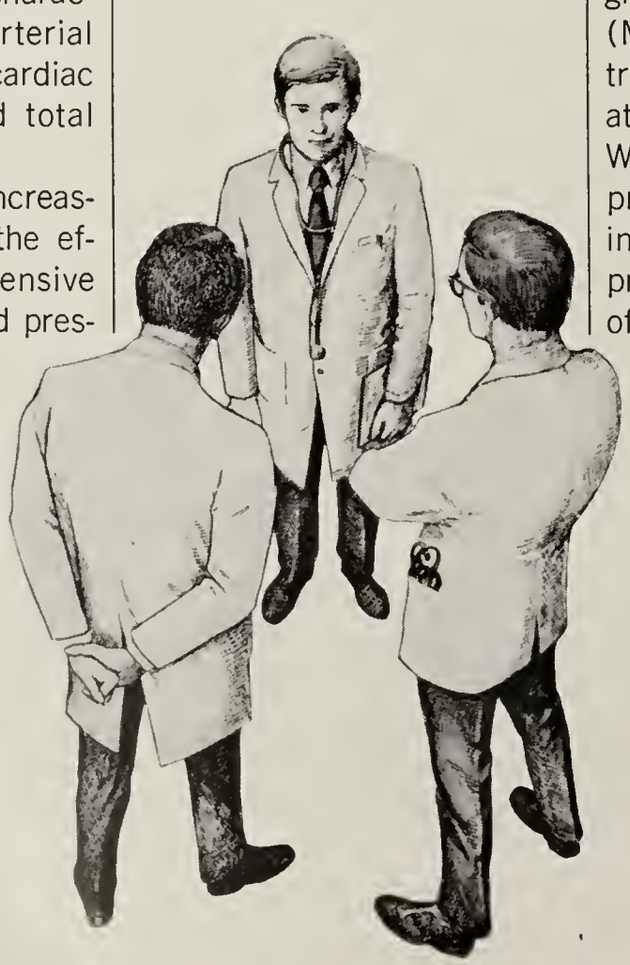
The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

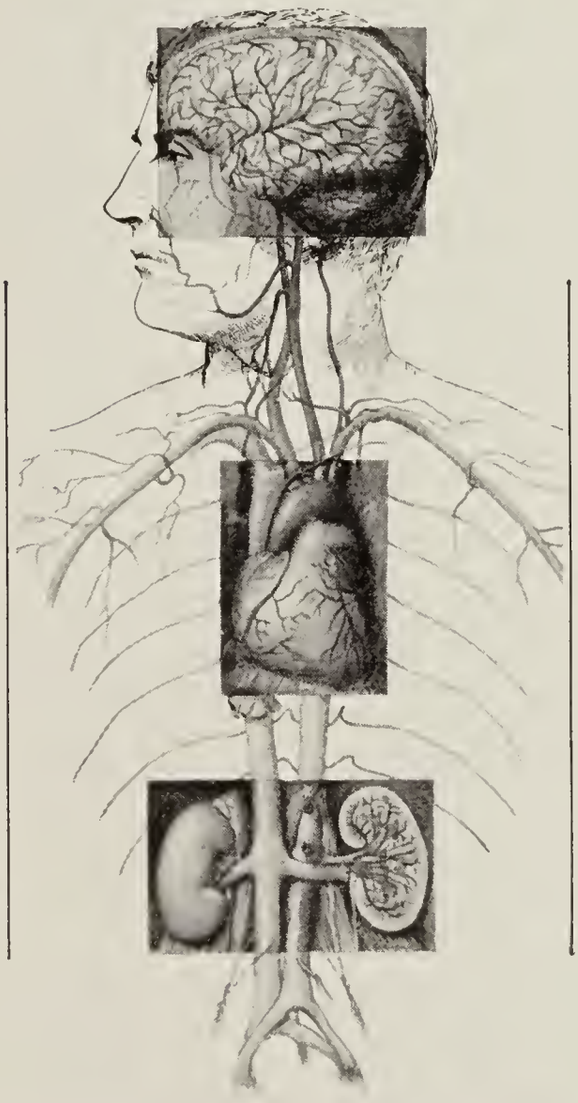
And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?

With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in



the more physicians rely on this unique antihypertensive



lowering blood pressure. But there are other considerations as well. Cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is actually slowed. Peripheral resistance is apparently reduced. ALDOMET does not usually compromise existing renal function; it generally does not reduce renal blood flow, glomerular filtration rate, or filtration fraction. And ALDOMET usually does not cause symptomatic postural or exercise hypotension.

Contraindications include active hepatic disease and known sensitivity to the drug. Use with caution in patients with a history of liver disease or dysfunction. Not recommended in pheochromocytoma or pregnancy.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

In most cases of sustained moderate hypertension

TABLETS, 250 mg and 500 mg

ALDOMET®

(METHYLDOPA | MSD)

smoothly lowers blood pressure

NEW now available in 500 mg TABLETS as well as the standard 250-mg tablets

For a brief summary of prescribing information, please see following page.

In most cases of sustained moderate hypertension

ALDOMET®
(METHYLDOPA MSD)

smoothly lowers blood pressure

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis. Known sensitivity. Not recommended in pheochromocytoma. Unsuitable in mild or labile hypertension responsive to mild sedation or thiazide therapy. Use cautiously in patients with history of previous liver disease or dysfunction.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between six and twelve months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at six and twelve months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first three weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first two to three months of therapy. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first six to twelve weeks of therapy or whenever an unexplained fever occurs. If fever, abnormalities in liver function tests, or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, reversible reduction in leukocyte count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur.

Use in Pregnancy and Childbearing Age—Not recommended in pregnancy. In women of childbearing age, weigh potential benefits against possible fetal hazards.

Precautions: Methyldopa may interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, spuriously high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has occurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: Sedation, usually transient, may be seen during initial therapy or when dosage is increased. Headache, asthenia, or weakness may be noted as early, transient symptoms. Symptoms associated with effective lowering of blood pressure are occasionally seen and include dizziness, lightheadedness, and symptoms of cerebrovascular insufficiency. Angina pectoris may be aggravated. Symptoms of orthostatic hypotension may occur; if symptoms occur, reduction of dosage is suggested. Bradycardia, nasal stuffiness, mild dryness of mouth, and gastrointestinal symptoms including distention, constipation, flatus, and diarrhea occur occasionally; these generally can be relieved by reducing dosage. Nausea and vomiting have been reported in only a few patients. Sore tongue or "black tongue," pancreatitis, and inflammation of salivary glands may occur.

Weight gain and edema occur infrequently and are relieved by administering a thiazide diuretic; if edema progresses or signs of pulmonary congestion appear, discontinue drug. A rise in BUN has been observed. Other rare reactions include breast enlargement, lactation, impotence, decreased libido, skin rash, mild arthralgia, myalgia, paresthesias, Bell's palsy, parkinsonism, psychic disturbances including nightmares, reversible mild psychoses or depression. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Note: Dosage should be limited initially to 500 mg daily when following previous antihypertensive agents other than thiazides. Maximal recommended daily dose is 3.0 g. Patients with impaired renal function may respond to smaller doses than patients with normal kidney function. Syncope in older patients has been related to increased sensitivity in those with advanced arteriosclerotic vascular disease; this may be avoided by lower doses. Tolerance occasionally seen either early or late, but more likely between second and third month after initiation of therapy; increased dosage or combined therapy with a thiazide frequently restores effective control.

How Supplied: Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486

addendum

MSD
MERCK SHARP & DOHME

"Required Reading" For Your Hypertensive Patients



Because of the importance of patient motivation, Merck Sharp & Dohme offers "High Blood Pressure," a concise, pocket-sized booklet that defines the patient's own role in the management of hypertension. This booklet is available for you to give to your patients. It is designed to reinforce your explanation of hypertension and it emphasizes the importance of patient understanding in adhering to the regimen you prescribe.

Please ask your Merck Sharp & Dohme Professional Representative or write Professional Service Department, West Point, Pa. 19486 for a supply of this booklet.

THE LITERATURE

Book Review

Stress Without Distress. By Hans Selye, M.D. 171 pages. New York: J. B. Lippincott, 1974. $6.95.

Dr. Selye implies that his treatise is written for the general reading public in the hopes it will help others keep on a steady course throughout life. His approach is generally an optimistic one.

The author reviews his earlier work on stress and the general adaptation syndrome. He points out that we cannot avoid stress and that we should not avoid it. Stress plays some role in the development of every disease. The effects of stress may be either helpful or harmful. Our bodies have the ability to provide defensive reactions on the cellular and interpersonal levels.

Dr. Selye's philosophy might be summarized as a philosophy derived from natural law extending from the biological to the psychological being of man. His credo is best stated as "Earn thy neighbor's love."

This book deserves reading by those of us in the medical profession, from the beginning freshman in medical school to the practitioners of the art of healing.

In the concluding paragraphs he gives a prescription for enjoying a full life.

1. Don't hoard love.
2. Strive for achievement; admit there is no perfection.
3. Adopt a simple, unpretentious life style.
4. Utilize repression constructively by having pleasant thoughts and forgetting unpleasant ones.
5. Face your problems, don't procrastinate.
6. One's performance should determine his progress.
7. There is no ready-made success formula to suit everybody.

There is an index, an excellent bibliography and a glossary to define terms used by Dr. Selye. There are several diagrams used in illustrating the text.

C. Duane Burgess, M.D.
Hattiesburg, Miss.

PERSONALS

Helen B. Barnes of Jackson and UMC has been appointed to the Mississippi Council for State Goals and Policies.

F. P. Bond announces the opening of his practice limited to obstetrics and gynecology at Suite 464, Hinds Professional Building, in Jackson.

Alfred W. Brann, Jr., of Jackson and UMC attended the University of Colorado symposium on perinatal health care at West Village, Aspen, Colo.

Ron Brass, Joji Kappes and Christine Klasen have been assigned by the National Health Service Corp to open a medical clinic in Tchula.

Alvin Brent, Jr., of Jackson announces the relocation of his office to 971 Lakeland Drive, Suite 415.

W. Joseph Burnett announces the opening of his office for the practice of ear, nose and throat, head and neck surgery and facial plastic surgery at 1121 Mimosa Drive in Oxford.

George J. Camatsos announces the opening of his office for general practice at 381 John R. Junkin Drive in Natchez.

Everett Crawford of Tylertown is the new president of the medical staff of the Tylertown hospital. He succeeds J. J. Pittman. Benjamin Crawford is the new secretary-treasurer and Jim McLain is vice president.

John Evans of Vicksburg was guest speaker at the Brotherhood and WMU meeting at the Vicksburg Bowmar Avenue Baptist Church. Dr. Evans spoke on "How to Postpone the Killer."

William Ray Fannin has been appointed clinical director of the Jackson Mental Health Center. Dr. Fannin completed his psychiatric training at the University of Florida.

CHARLES FARMER of Jackson has been elected president for 1974-75 of the Hinds County Unit, American Cancer Society.

MARK F. HARTLEY of Sardis was honored with a reception and appreciation day at the Sardis National Guard Armory. Dr. Hartley has since moved his practice to Waverly, Tenn.

ADAM CHARLES HUNTER of Columbus was presented with a certificate of appreciation by the medical staff and board of trustees of Lowndes General Hospital upon his retirement due to ill health.

JOHN F. JACKSON of Jackson and UMC presented a paper at the symposium on practical genetics for the family physician in Birmingham in September.

J. C. LONGEST of Starkville was guest speaker at the Mississippi Interagency Council on Smoking and Health meeting held in Natchez.

BENSON B. MARTIN, JR., and S. I. FEURST announce the removal of their offices from the Martin-Feurst Clinic, 2901 Washington Street, to the Medical Arts Clinic, 1401 Adams Street.

E. L. MCAMIS announces the opening of an office in Port Gibson for the practice of medicine and surgery.

JOHN H. MCCANN, JR., JOHN G. WALROD and RODNEY R. CHANDLER are now providing fulltime coverage of the emergency room of Forrest General Hospital in Hattiesburg.

WILLIAM C. MCQUINN of Jackson recently attended a six-day workshop for training in Group Psychotherapy. This workshop was conducted by Dr. William H. Holloway, director of the Midwest Institute for Human Understanding in Medina, Ohio. Dr. McQuinn was installed as a Fellow in the American Psychiatric Association in May.

JOE R. NORMAN of Jackson and UMC attended a symposium for new techniques for fibroptic bronchoscopy at the University of Colorado at Denver.

H. K. OEI announces the opening of his office for the practice of internal medicine and cardiology in the Pittman Clinic, 1211 Magnolia Avenue in Tylertown.

JOHN B. O'KEEFE and FRANK SCHIAVI, JR., announce the removal of their office to Biloxi Orthopaedic Clinic, P.A., Gulf National Life Building, No. 1 Central Beach in Biloxi.

S. RAY PATE of Jackson announces the removal of his office for the practice of psychiatry on Tuesday and Thursday to 3311 Frontage Road in Vicksburg.

W. H. PRESTON, JR., of Booneville, district governor for Rotary International, spoke at the weekly meeting of the Clarksdale Rotary Club.

RONALD E. RENNICK from Oliver, British Columbia, has set up practice in Okolona.

JOHN F. RUSSELL of Gulfport has been named state drug abuse chairman by the Mississippi Academy of Family Physicians.

AZHAR SAIFUDDIN is the new pathologist at Tishomingo County Hospital.

A. J. SANTANGELO announces the removal of his office to 1062 Riverside Plaza on Lakeland Drive for the practice of psychiatry.

MICHAEL SHAHEEN of Como was featured in an article in the Commercial Appeal's Mid-South Magazine.

GEORGE V. SMITH of Jackson and UMC attended the 1974 Chicago Symposium on Immunotherapy.

RALPH SNEED of Jackson announces the association of TERRELL D. BLANTON in the practice of otolaryngology at the Jackson Ear, Nose and Throat Clinic, 916 North State Street.

DON TURNER of Jackson was a guest speaker at the October 4 Millsaps College forum. He discussed preservation of transplanted organs: medical and ethical implications.

HENRY B. TYLER of Jackson was guest speaker at the September meeting of the Northeast Mississippi Medical Society held in Aberdeen.

W. L. WALDRON of Jackson announces the removal of his offices for the practice of psychiatry to 1060 Riverside Plaza.

NEW MEMBERS

GUESS, CHARLES D., Jackson. Born Jackson, Miss., Oct. 30, 1939; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned Georgia Baptist Hospital, one year; elected by Central Medical Society.

DEATHS

DABBS, ROME GRAFTON, Shannon. Born Nettleton, Miss., Aug. 27, 1875; M.D., Memphis Medical Hospital, Memphis, Tenn., 1901; interned private infirmary, Aberdeen, one year; Emeritus member of MSMA and AMA; member of Fifty Year Club of MSMA; died July 1, 1974, age 98.

LETTERS

SIRS: Zoster immune globulin (ZIG) is again available for distribution through the Center for Disease Control's ZIG program. Patients eligible for ZIG prophylaxis are children with predisposing high-risk conditions (leukemia or lymphoma, an immunodeficiency syndrome, or treatment with immunosuppressive medications) who have been exposed to an active case of varicella within the preceding 72 hours. Adults, children with already established varicella-zoster infection, and children with previous history of varicella-zoster infection are not eligible for ZIG prophylaxis. ZIG will be distributed according to the following dosage schedule:

Weight (kg)	*Dose (ml)*	*No. of Vials*	*Weight (kg)*	*Dose (ml)*	*No. of Vials*
0-10	1.25	1	20-30	3.75	3
10-20	2.50	2	Over 30	5.00	4

The maximum dose will remain 5 ml; ZIG is administered intramuscularly.

Because ZIG is an investigational preparation, physicians caring for children who receive it are requested to obtain serum samples before ZIG administration, 48 hours after administration, and 4 weeks after administration and to supply to CDC clinical follow-up data for 30 days after treatment.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

Miss. SBH Receives Hypertension Grant

The Mississippi State Board of Health has received a $952,854 grant from the Mississippi Regional Medical Program for the funding of a hypertension control program utilizing community health departments, according to Dr. Durward Blakey, chief of the Bureau of Disease Control.

The Mississippi Regional Medical Program (MRMP) through its regional advisory council directs funding to meet identified Mississippi needs while acting as an intermediary funding agency of the Department of Health, Education and Welfare. The University of Mississippi Medical Center serves as a grantee for the MRMP.

"I know of no disease in Mississippi more prevalent, more serious, more out-of-control, and yet more preventable and curable than that of hypertension or high blood pressure," Dr. Blakey said.

"Although we have public health programs aimed at many prevalent diseases such as cancer, diabetes, infectious diseases, sickle cell, and others, none could be more easily controlled than hypertension," he said. "And yet no specific effort has been made in this direction, probably because of the enormity of the task."

Hypertension clinics are planned to be held statewide to find possible high blood pressure patients, according to Dr. Blakey.

"Hypertension is a chronic disease which strikes particularly hard in the low income groups and affects many young as well as middle aged and older wage earners," he said.

"High blood pressure, unlike other chronic illnesses, is even serious among young adults," Dr. Blakey said. "For example, during the period of April-December, 1973, high blood pressure (140/90) accounted for 9.14 per cent of all armed services inductee disqualifications throughout the nation, but 18.76 per cent of all disqualifications in Mississippi."

"While the need for a hypertension detection and treatment program is evident in all segments of population in Mississippi, there is one segment for which the need is acute and almost an emergency situation —Mississippi blacks," Dr. Blakey said. "A 1971 nutrition survey of blacks in Holmes County found that 33.3 per cent of males and 39.7 per cent females had high blood pressure."

"Through this program, hypertension can be reduced in the vast majority of persons with elevated blood pressures," he said. "These reductions will result in lower complications from cardiovascular diseases and significantly reduce the risk of mortality from subsequent cardiovascular diseases and significantly reduce the risk of mortality from subsequent cardiovascular complications such as strokes, kidney failure and other serious and often fatal illnesses."

"We plan to implement this program by mobilizing community forces and focusing them on this problem through local health departments," he said.

Athletic Injury Seminar Held at Gulfport

The annual Athletic Injury Seminar for the area schools was held on Aug. 5 at Memorial Hospital in Gulfport. Approximately 15 physicians and 100 coaches and trainers were present.

Topics presented were minor foot disorders by Dr. Ed Hamilton of Gulfport; hyperventilation by Dr. George Thomas of Gulfport; sprains by Dr. Griffin Bland of Gulfport; diagnosis of heat disorders by Dr. W. W. Lake of Gulfport; and classification of major football injuries by Dr. Ray Hadad, orthopedic consultant for the New Orleans Saints. Dr. A. C. Hewes of Gulfport was moderator.

Dr. Webre Joins UMC Faculty

Dr. Donald Ray Webre has joined the University of Mississippi School of Medicine faculty at the Medical Center in Jackson.

Vice Chancellor Dr. Norman C. Nelson announced the appointment following action of the Board of Trustees, Institutions of Higher Learning.

Dr. Webre is an assistant professor of anesthesiology.

An alumnus of St. Joseph's Seminary, St. Benedict, La., Louisiana State University, Baton Rouge, and Loyola University, New Orleans, he got the B.S. degree from LSU in 1965 and the M.D. degree from LSU School of Medicine at New Orleans in 1969.

Dr. Webre interned at Charity Hospital in New Orleans and did a residency and fellowship at Ochsner Foundation Hospital in New Orleans.

Before joining the UMC faculty, he was in the U. S. Navy.

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic)
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands, no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults – 600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule. 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia 900 mg daily for six days.
Children – 3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE LABORATORIES
CRANBURY, NEW JERSEY 08512

North Mississippi Medical Center Serves A Large Area of the State

Serving several nearby counties and with referrals from as far away as Alabama and Tennessee, the North Mississippi Medical Center serves as a nucleus of medical care activity in Northeast Mississippi.

With over 60 physicians practicing in Lee County, the medical center is able to offer all specialty services except open heart surgery.

The concept of a regional medical center "just evolved over the years," according to Dan Wilford, youthful administrator of NMMC. Roughly half of all medical care rendered is to residents of Lee County; the other 50 per cent of patients come from surrounding areas.

The medical center is the biggest employer in the county with over 1,000 employees. Hospital budget for 1975 will be approximately $15,000,000, noted Wilford.

The complex is composed of three main buildings: the hospital with 300 beds, the nearby Belle Vista Unit with 100 beds, and the Satellite Unit at Baldwyn consisting of 35 beds. The Belle Vista Unit was originally an extended care facility. In 1967 it was partially converted into 75 acute beds. The 18-bed psychiatric service has also been transferred to Belle Vista.

Construction has now begun on a 100-bed addition to NMMC and a 15-bed addition at Baldwyn. The hospital has been running at full capacity, according to Wilford who said that in September general medical and surgical beds reached a 97 per cent occupancy rate.

Remodeling is currently being done on the obstetrical floor. When finished in December, the 30-bed unit will contain modern delivery and labor



This architectual drawing shows how North Mississippi Medical Center will look when additions now under contract are completed in about two years.

rooms and newborn nursery. The third floor of the hospital is being renovated into a 43-bed medical-surgical unit.

The remodeling projects and two additions add up to a total cost of $4.5 million, said Wilford. The construction is financed by county bond issue in which the hospital repays half of the $4.5 million.

The administrator admitted that staffing the new additions might be a problem but it is hoped that the nursing schools at Itawamba Junior College at Fulton, Northeast Mississippi Junior College at Booneville and Mississippi University for Women at Columbus will help provide nurses. At present, all three schools send students to NMMC for phases of their clinical training.

The hospital has made other commitments to medical education. University Medical Center residents in general surgery and ob-gyn rotate for three to four months at the Tupelo institution and MECO students are sponsored each summer.

Situated on the hospital grounds is the regional mental health complex which serves eight counties. The yearly budget of $469,000 is financed mainly through federal, mental health and Appalachian Regional Commission grants. Counselors operate in each county and refer patients, when necessary, to the Tupelo complex. The program includes group therapy, day care, after care programs, crafts, and industrial programs for alcohol and drug abusers. Staff consists of a psychiatrist, psychologists and social workers.

The NMMC emergency room has fulltime coverage and the hospital runs the ambulance service. There are over 3,000 ER visits monthly and some 200 ambulance runs are made each month. There are 12 ambulance drivers and a supervisor, all of whom are trained emergency medical technicians.

Other special services include a hospital-based home care program with a current patient load of 53. A registered nurse and licensed practical nurses provide continuation of hospital care by calling on these patients at home for routine lab work and checkups.

The hospital has a kidney dialysis program which receives support from the Appalachian Regional Commission, Mississippi and Memphis Regional Medical Programs, the Rotary Kidney Foundation and the Northeast Mississippi Kidney Foundation. District Rotary clubs alone provide $30,000 a year to help maintain the five machines. Nurses and technicians were trained at the University Medical Center in Jackson and Dr. John Bower from UMC conducts a monthly clinic in Tupelo.

The medical center also boasts an argon laser beam for ophthalmological use. Federal grants and local funds helped pay for this equipment.

NMMC charges to patients remain below the national average for hospitals of its size and below the Mississippi average for hospitals with over 100 beds. This is attributed to studied efficiency, a light charity load and central purchasing and laundry.

Bed breakdown is about 260 private beds, 148 semiprivate and 15 ward beds at Tupelo. The Baldwyn unit has all private beds, but its new addition will add six semiprivate beds.

The success and continued growth of the North Mississippi Medical Center is the direct result of a



Work has also started on a 15-bed addition to the Baldwyn Satellite Unit.

positive attitude and support of the city and county together with a cooperative and forward-looking medical staff, according to Wilford. It's a unique situation.

Blue Shield Clarifies "Reciprocity" Plan

In April of 1971, the National Association of Blue Shield Plans instituted a new program designed to help overcome problems experienced by physicians and subscribers with out-of-area claims. Identified as Reciprocity, the program has been labeled as one to "see that the patient and the doctor are always treated right."

Reciprocity was started on a limited basis in order to test the system, but Blue Shield now expects to have more than 10 million Reciprocity subscribers by the end of this year.

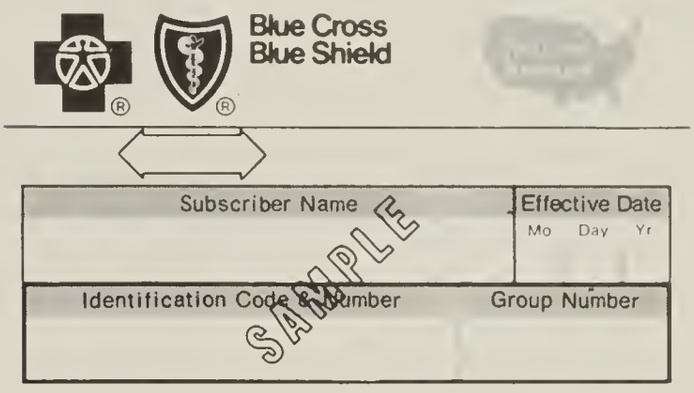
Under Reciprocity, a physician will receive the Usual, Customary or Reasonable fee for covered services rendered to an eligible subscriber. Those in the program can be easily determined by a double-pointed red arrow appearing on the Blue Shield identification card. (See accompanying illustration.) The number printed inside the red arrow indicates the Blue Shield Plan which issued the card.

When a physician provides medical service to a patient enrolled under Reciprocity by an out-of-area Blue Shield Plan, the claim is submitted directly to, and payment is received from, the doctor's own local Blue Shield Plan.

When preparing a claim for services rendered to a Reciprocity covered patient, the local Blue Shield claim form which the doctor normally uses should be filled out in the usual fashion. The only exception is that the numbers appearing inside the red arrow on the ID card must be included in the appropriate space on the claim form.

Properly completed, the claim forms for Reciprocity subscribers should be sent to the doctor's own local Blue Cross and Blue Shield Plan along with all other "regular" claims. Reciprocity claims will be processed immediately and the provider will receive his Usual, Customary or Reasonable fee directly from the local Plan. Blue Shield handles its paperwork *after* payment has been made to the physician.

"The important thing for the physician and his assistant to remember when they see the double-pointed red arrow on one of our identification cards is that the local Blue Shield Plan is assuming responsibility for payment to the physician for covered services," according to Ned F. Parish, president of the National Association of Blue Shield Plans.



Blue Cross and Blue Shield of Mississippi is in the process of conducting an extensive education program for all medical assistants designed to facilitate administration of Reciprocity claims. However, it is pointed out that any physician or medical assistant who has questions regarding the program should contact their Blue Shield Professional Relations representative.

The National Association of Blue Shield Plans is the world's largest private prepayment organization, providing services to over 80 million Americans.

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The Upper Functional G.I. Disorder

The Pseudo-ulcer

Ulcer-like symptoms: no G.I. pathology



X-ray demonstrates normal stomach.

The patient is convinced he has an ulcer. However, symptoms are not quite typical, and x-ray findings are negative. These findings and the results of additional diagnostic procedures exclude an organic basis for the patient's complaints. A diagnosis of "upper functional gastrointestinal disorder" is made, which is supported by the fact that episodes of painful symptoms coincide with episodes of excessive anxiety, as indicated by the history.

It may be useful to explain to the patient the mechanism by which emotions upset normal G.I. functioning, resulting in hypersecretion and hypermotility and thus causing such symptoms as nausea and epigastric pain. In upper functional gastrointestinal disorders, counseling by the primary physician can often help the patient understand how excessive anxiety may cause flare-ups of G.I. symptoms.

A disproportionate number of patients seen by the general practitioner suffer from functional disorders, as do more than half of those seen by the gastroenterologist.* Where milder cases may respond to counseling alone, if symptoms are severe and disabling to any degree, a suitable regimen may include medication to reduce the symptoms and the excessive anxiety that often provokes these distressing symptoms.

In these cases, Librax as an adjunct can greatly contribute to the course of therapy. Its dual action can offer relief of both painful symptoms and excessive anxiety, because each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br. The antianxiety action of Librium® (chlordiazepoxide HCl) makes Librax exceptional among drugs for certain gastrointestinal disorders associated with excessive anxiety; the clidinium bromide (Quarzan™) component furnishes dependable antisecretory-antispasmodic action. Dosage is flexible; it may be adjusted according to your patient's requirements within the range of 1 or 2 capsules three or four times daily, up to 8 capsules daily in divided doses. Please consult the complete product information regarding precautions and adverse reactions.

*Rome HP, Brannick TL: Orientation and mechanism of functional disorders; clinicophysiologic correlation, chap. 133, in *Gastroenterology*, edited by Bockus HL. Philadelphia, W. B. Saunders Company, 1965, p. 1116.

An adjunct in anxiety-related upper functional G.I. disorders

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

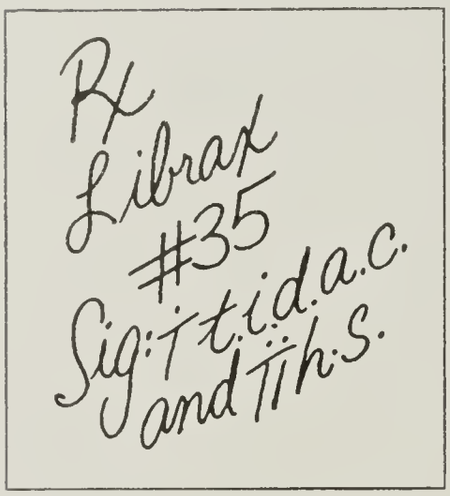
ROCHE

Please see summary of product information on following page.

An adjunct in anxiety-related upper functional G.I. disorders

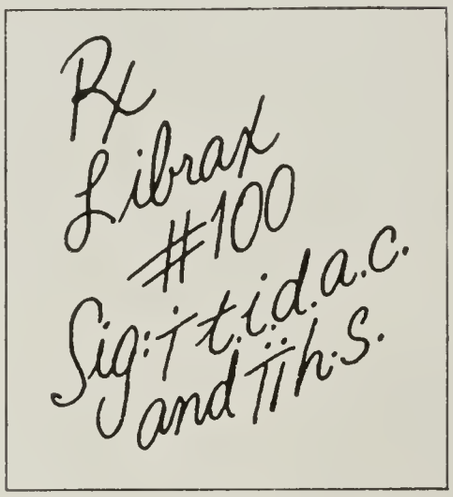
Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.



Initial therapy

The initial prescription allows evaluation of patient response to therapy.



Follow-up therapy

Follow-up therapy with a prescription for 2 to 3 weeks' medication usually helps maintain patient gains.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders; and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax® Capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan™)—bottles of 100 and 500.

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AAP Journal Reports On Thumb-Sucking

Thumb-sucking in the young child is simply a common learned behavior rather than a sign of emotional disturbance, a Rochester, N. Y., pedodontist has reported in the August issue of *Pediatrics,* the official publication of the American Academy of Pediatrics. "There is no evidence to substantiate the theory that prolonged sucking habits result from emotional disturbances," M. E. J. Curzon emphasized in the AAP journal.

The pedodontist, from the Department of Pedodontics, Eastman Dental Center, Rochester, N. Y., said further that no relationship has been found between the thumb-sucking habit and the child's sex or place in line of siblings. He cited one study which showed that 45.6 per cent of American children under the age of 4 years suck their thumbs.

To parents of children with the thumb-sucking habit, Curzon offered this advice: In the small infant, it must first be determined that the baby is getting enough nursing to satisfy its need for oral gratification. If he is not, a pacifier may be prescribed. A pacifier is far more readily given up at a later age than thumb-sucking, Curzon pointed out.

If the child with a thumb-sucking or finger-sucking habit is under three three years of age, parents should ignore the habit, rather than drawing attention to it. "It should be pointed out that finger-sucking is normal in a large percentage of infants and that in all probability the habit will be voluntarily given up by the age of four years," Curzon indicated. "It is imperative that the parents cease to be overanxious."

If the habit still persists at the age of four, Curzon said, and especially if it is constant throughout the day, concern is warranted. At this stage parents are advised to consult a pedodontist or general dentist for advice and possible treatment. Curzon emphasized that malocclusions arising from prolonged finger- and thumb-sucking cause considerable distress and disfigurement. And he indicated that the incidence of malocclusions following or accentuated by oral habits is therefore high enough to be considered serious.

"By school age, there is . . . a hard core of children still with an oral habit which in a small percentage of cases may persist, if allowed, into adolescence," Curzon stated.

"It is important to appreciate that this period of 4 to 14 years coincides with the period of greatest dentofacial development. Thumb-sucking in this age group must be considered serious, and steps taken to wean the child from the habit and minimize or correct ensuing dental deformities."

SBH Will Have Influenza Vaccine

The Mississippi State Board of Health will again offer influenza vaccine to high-risk patients enrolled in the agency's Chronic Illness programs, according to Dr. Laurance Clark, director of the Chronic Illness Program.

"Repeated observations during influenza epidemics show that mortality is almost completely restricted to the chronically ill and elderly, especially those over 65," Dr. Clark said. "Persons in these categories, not enrolled in health department programs should contact their physicians to arrange for influenza vaccination."

Some 100,000 doses of vaccine will be required and the entire operation by the Board of Health to those in its Chronic Illness program is to be completed by mid-November, according to Dr. Clark.

"Only one dose of vaccine is necessary this year," he said. "Multiple doses are no longer recommended even for those being vaccinated for the first time."

"Second doses within a given year do not increase antibody levels significantly and the only occasion for more than one dose would be the late appearance of a new virus," Dr. Clark said.

This year, only the new 1974-75 bivalent vaccine is being used, according to Dr. Clark. Each dose contains 1200 CCA units of 700 CCA, Type A (A/Port Chalmers/1/73 (H_3N_2) and 500 CCA, Type B (B/Hong Kong/5/72).

"Influenza occurs every year with wide variation in extent and intensity," Dr. Clark said. "Despite the presence of two new viral agents, Mississippi experienced a relatively light flu season during 1973-74. We expect that a high level of upper respiratory syndrome will be of general occurrence and influenza will occur in sporadic outbreaks."

"Influenza vaccine is the best available means for protecting those at highest risk," Dr. Clark said. "The unusual severity of influenza on the aged and the chronically ill of any age is well documented. Consequently, the State Board of Health recommends the selective vaccination of high risk groups."

Medic Alert Services Explained

Medic Alert is tax-exempt, nonprofit, and charitable—the world's largest provider of emergency medical identification services.

That service is in three parts. First, there is the alerting device bearing the red Medic Alert emblem, worn as a bracelet or necklace. That speaks for the member in an emergency when he can't communicate. Medical information engraved on the reverse side is backed up by the second part of the service, a wallet card bearing additional personal and medical information. Finally, there is the computerized data base that can be accessed by emergency personnel on a 24-hour basis by calling collect to the telephone number indicated on the alerting device. This provides whatever emergency information the member and his physician believe will best serve him in an emergency.

The need is great. The AMA reports that 20 per cent of all persons have some special medical condition. That's one out of every five patients served by each physician.

Medic Alert members are encouraged on a regular basis to obtain counsel of their physicians so that the 24 hour emergency file will best serve the member during a critical medical situation. An important aspect of the service is the update letter. Mailed each year, it provides the member with a copy of his computerized information record allowing him to verify his emergency record. The member is strongly encouraged to review this information with his physician. This assures that his membership is an accurate extension of the care his physician would like him to receive in a medical emergency.

In pursuit of working with medical organizations, the Medic Alert Foundation conducts an ongoing effort of providing educational literature at no cost. Of particular interest is the folder "This Could Save Your Life" which contains a Medic Alert application form. Displayed in a stand-up container, these are available in thousands of hospitals and physicians' waiting rooms nationally.

For more information or for the free application forms write Medic Alert Foundation, Turlock, Calif. 95380.

Stopping Smoking Increases Survival

Stopping the cigarette habit appears to increase one's prospects for survival, even if this is done relatively late in life and after many years of smoking.

This is one of the findings reported in *Smoking and General Mortality Among U. S. Veterans, 1954-1969* (DHEW Publication No. [NIH] 74-544) just published by the National Heart and Lung Institute and available on request from the NHLI Public Inquiries and Reports Branch, Bethesda, Md. 20014.

The report describes mortality related to the use of tobacco among 293,958 U. S. veterans who held Government Life Insurance policies in 1953.

A questionnaire on smoking habits was circulated to this group in 1954 and again in 1957. Nearly 250,000 replied—a response rate of 85 per cent.

Mortality data were obtained from the Veterans Administration, which provided the names of policy holders who died during the 16-year period from Jan. 1, 1954 through Dec. 31, 1969. In addition, special searches were made for 75,000 veterans whose policies terminated between 1963 and 1969, so that the overall mortality follow-up was virtually complete.

Among the findings reported from the survey:

—Persons who had never smoked had the lowest probability of death during the 16-year period of followup.

—Mortality levels were highest among cigarette smokers, followed by cigar and pipe smokers. In each category, mortality risk was related to the amount smoked.

—Among persons smoking more than one form of tobacco—cigarettes and pipes, for example—mortality risk tended to split the difference between categories, being somewhat lower than that for cigarettes only, but higher than that for pipes only.

—Among persons who stopped smoking cigarettes—for reasons other than doctors' orders—mortality risk was lower than that among persons who continued to smoke. It remained higher than the mortality risk of persons who had never smoked, but declined as the period of abstinence increased until, after prolonged abstinence, it was only slightly higher in some groups of ex-smokers than that of nonsmokers.

For example, the 16-year mortality rate for men between the ages of 45-54 years who smoked more than 20 cigarettes per day was 32.3 per cent, for the

same aged nonsmokers it was 14.7 per cent and for men who stopped smoking for some reason other than doctor's orders it was 21.4 per cent. If we look at the age group 55-64 years, for those who smoked more than 20 cigarettes per day the mortality rate for smokers was 49.6 per cent, for ex-smokers it was 37.3 per cent and for nonsmokers it was 28.5 per cent.

The study was done by Mr. Eugene Rogot of the NHLI Epidemiology Branch in collaboration with the Veterans Administration and with contributions from other scientists of the National Institutes of Health.

SmithKline Markets Influenza Vaccine

SmithKline Corporation is the first company in the world to receive permission to market a live, intranasal vaccine against influenza.

The new vaccine, which has been approved by the Belgian authorities, will be available for the 1974-75 flu season in Belgium.

The new vaccine offers important advantages over currently available flu vaccines. Because it is a live virus vaccine, scientists believe it offers better protection against influenza than killed virus vaccines. Also, since it is administered in the nasal passages rather than by injection, the new vaccine produces local immunity in the upper respiratory tract where the influenza viruses enter the body, as well as systemic protection.

The value of this relatively new concept of local immunity has already been demonstrated by the live virus, oral polio vaccines, which establish local immunity to polio in the gastrointestinal tract where the virus first establishes itself.

Thousands of persons have been inoculated with the new vaccine in clinical studies in Belgium, the United States and Australia to establish safety and efficacy. It protects against current variants to the influenza A virus circulating since 1968.

The SmithKline vaccine is well tolerated and does not cause virus transmission. Preventive vaccination is the only effective medical weapon against influenza, the only remaining infectious disease that continues to appear in life-threatening, worldwide epidemics.

The development of this new live virus influenza vaccine has been achieved by the team of researchers at Recherche et Industrie Thérapeutiques, a Belgian subsidiary of SmithKline Corporation, who a few years ago developed the first vaccine against rubella (German Measles) to be marketed in the world. They are Dr. Constant Huygelen, director of the Biologics Department, who directed the laboratory research; and Dr. Abel Prinzie, Area Medical Director, Continental Europe, who was responsible for the direction of the worldwide clinical work establishing the safety and efficacy of the vaccine.

A & I Board Sponsors Photography Contest

"Mississippi is Photogenic" is the theme of the photography contest being sponsored by the Public Affairs Department of the Mississippi Agricultural and Industrial Board. The contest is designed to stimulate not only the photographer's awareness of the beauties of our state, but all Mississippians as well.

The contest will continue through Dec. 31, 1974, and is open to both the professional and amateur photographer. Entrants may choose their subject matter, but emphasis should be placed on scenic attractions in the state. All photos must be taken in Mississippi.

Participants may submit up to four entries in each of three categories: black and white prints, color prints and color transparencies, including 35mm slides. A jury of qualified judges will select up to five awards of merit in each of the three categories in the professional and non-professional classifications and trophies will be presented for best of show.

After a formal presentation and showing of winning entries, plans call for a traveling exhibit throughout the state.

For official entry forms and information regarding rules, contact the Public Affairs Department of the Mississippi A&I Board, 1505 Walter Sillers Building, Post Office Box 849, Jackson, Miss. 39205.

Kennedy's Medical Draft Program Defeated

The Senate has overwhelmingly passed legislation that would require one-fourth of all medical and dental school graduates to spend at least two years in the nation's slums and rural areas where there are shortages of physicians.

Before the first Senate vote, Senator Kennedy, aware that he was losing liberal support, shelved his Health Subcommittee's $5.1 billion, five-year bill and offered a substitute measure which was trounced 57-34. Instead the Senate adopted a measure sponsored by Senator J. Glenn Beall, Jr. (R-Md.) and went on to pass a three-year, $2 billion health manpower bill by a vote of 81-7. Senators Eastland and Stennis voted for defeat of the Kennedy measure and passage of the Beall substitute.

The bill finally approved by the Senate was stripped of most of the controversial provisions of the original Kennedy bill and was a victory for the American Medical Association, the American Dental Association, and the Association of American Medical Colleges.

The Senate bill calls for a three-year extension of present federal programs for aiding medical education at a total cost of about $2 billion. Capitation grants for medical schools would be continued at a high level despite the administration's request for a cutback.

The Beall substitute measure provides federal aid to medical and dental schools that agree to allocate 25 per cent of their classroom space to students volunteering to serve in areas short of medical care workers. In return for either civilian or federal service under the National Health Service Corps, the students would receive scholarships.

The Kennedy bill would have compelled all medical school graduates to serve in the shortage areas, an approach labelled a "domestic draft" by Senator Beall and his committee colleagues Senators Peter Dominick (R-Colo.), and Robert Taft, Jr. (R-Ohio), who developed the substitute measure.

Another casualty of the Senate voting was the proposal for federal standards for licensing and relicensing physicians and dentists, a plan that stirred wide protest within the professions.

The Maryland Senator's bill represented a middle ground on financial help for medical schools, with the AAMC contending the amount was too low and the Administration believing it was too high.

Immigration standards would be tightened to restrict the number of foreign medical graduates under the Senate bill.

Record Gains Reported In CME

The American Medical Association's 20th annual compilation of continuing education courses for physicians lists 3,677 courses offered by 876 institutions in 44 states and the District of Columbia in the year Sept. 1, 1974-Aug. 31, 1975.

This is a major increase over the number of courses offered in the current year (2,441), and is the largest increase in the number of courses ever reported in a single year, says the report.

The list is published each year as a service to all physicians who are interested in maintaining their competence and skill through formal courses and other organized activities in continuing education.

A major stimulus to continuing education in medicine has been the American Medical Association's Physician's Recognition Award. This is a certificate presented to those who have successfully completed 150 hours of continuing education courses in a three-year period. More than 13,000 physicians qualified for the award in 1973. There are now 24,498 physicians in the United States who hold a valid award.

Eleven state medical associations have adopted programs that may have the effect of requiring continuing medical education as a condition of membership, and others have the subject under consideration. Many of the medical specialty societies also are in process of instituting similar requirements. Four states now have permissive legislation that authorizes a requirement of continuing education as a part of the process of reregistering the license to practice medicine.

The listing was compiled by the staff of the AMA's Department of Continuing Medical Education, C. H. William Ruhe, M.D., Rutledge W. Howard, M.D., Clarke W. Mangun, Jr., M.D., and Charlotte Hartman.

JOURNAL

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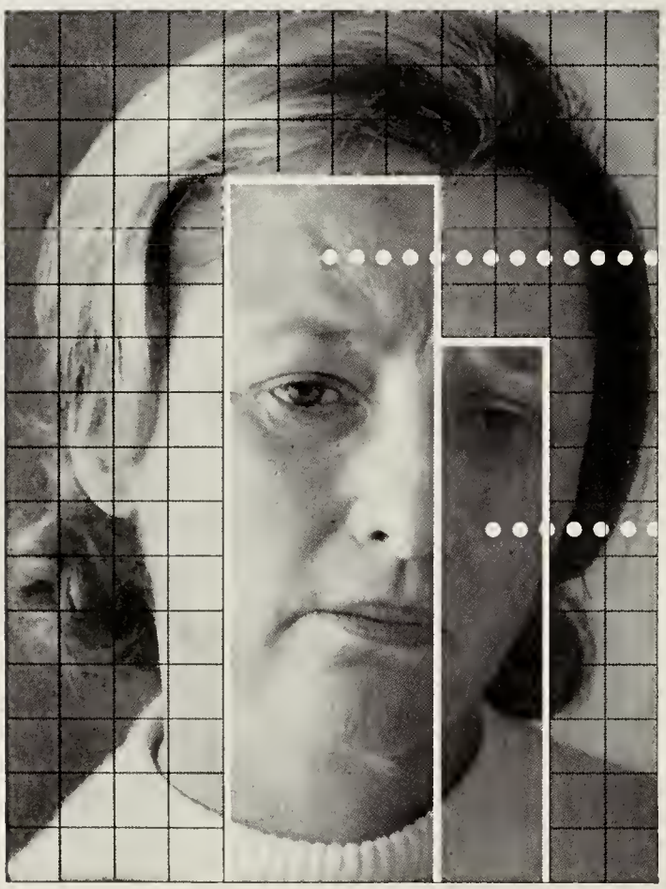
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This Month . . . Thoracic Aortic Aneurysms, Recurrent Radial Nerve Palsy, Renal Cysts

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Volume XV
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December 1974



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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The Upper Functional G.I. Disorder

The Pseudo-ulcer

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
December 1974, Vol. XV, No. 12

ORIGINAL PAPERS

Thoracic Aortic Aneurysms

JAMES D. HARDY, M.D., and
AKIO SUZUKI, M.D.
Jackson, Mississippi

Most thoracic aneurysms are asymptomatic and are discovered on routine chest x-ray. Surgical management of these aneurysms is now routine and these serious lesions can be resected with a low operative mortality rate in otherwise good risk patients. The authors discuss etiology, diagnosis, surgical management and results in 67 patients treated at University Hospital.

THE SURGICAL management of aneurysms of the thoracic aorta is now routine. These serious lesions can be resected with a low operative mortality rate in otherwise good risk patients. However, developments in our knowledge continue to unfold, and this renders aneurysm surgery a still challenging field.

The etiology of thoracic aortic aneurysms has changed radically since the advent of penicillin for the treatment of syphilis. Whereas in the 1940's luetic thoracic aneurysms were common, the large majority of thoracic aortic aneurysms now encountered are due to atherosclerosis, while still others are due to non-infectious diseases of the aortic wall such as trauma, cystic medial necrosis or true Marfan's syndrome. In a recent survey of 67 non-dissecting thoracic aneurysms treated at University Hospital, only seven patients had exhibited a clearly positive serology for syphilis. Thus, while lues may have been a factor in a few additional cases, it is clear that the incidence of this infection as a cause of thoracic aneurysms has declined markedly over the past three decades. Thoracic aneurysms occur principally during the sixth, seventh, and eighth decades of life (see Figure 1).

It is important to make a distinction between true aneurysms and dissecting aneurysms. In general, atherosclerotic aneurysms occur without dissection, and systemic arterial hypertension is not necessarily a component of the clinical picture. In contrast, the true dissecting aneurysm is usually associated with hypertension, and it is not often secondary to a previously existing true aneurysm. However, a dissecting component does at times develop in a true aneurysm and, conversely, what was believed to be a true aneurysm may be found at operation to represent aneurysmal dilatation at the site of a previous dissection. There is therefore a degree of overlap between true aneurysms and dissecting aneurysms.

Traumatic aneurysms usually follow blunt or deceleration injury, as in automobile or airplane accidents. This lesion frequently represents a tear or even transection of all elements of the aortic wall except the adventitia, most often just distal to the left subclavian artery. When the adventitia is also divided the parietal pleura may confine the blood for variable periods of time, but sooner or

From the Department of Surgery, University of Mississippi Medical Center, Jackson, Miss.

later exsanguination into the left hemithorax usually occurs if all layers of the aortic wall have been divided.

In our survey of 65 patients with true thoracic aortic aneurysm at University Hospital, it became clear that the threat of massive hemorrhage from a thoracic aortic aneurysm is scarcely less than that from an abdominal aortic aneurysm.

DIAGNOSIS

The asymptomatic thoracic aortic aneurysm is most often first noted on a plain chest x-ray, but the symptomatic aneurysm may have prompted the roentgen study as a part of the diagnostic work-up (see Table 1). The diagnosis of aneurysm, suspected from the plain chest x-ray (see Figure 2), is confirmed with aortography (see Figure 3). The most important diagnostic considerations, relative to the mediastinal mass seen on chest x-ray, are that an aneurysm does exist, its approximate location, and whether or not or where the great vessels of the aortic arch are involved. The most common site of origin of atherosclerotic aortic aneurysm has been in the region of the left subclavian artery, but the aneurysm may arise at any site—the ascending aorta, the arch with involvement of all the great vessels, the descending aorta, or the lower thoracic aorta extending into the abdomen (see Figure 4). Again, traumatic aneurysms of the aorta usually occur in the descending aorta at the level of the ligamentum arteriosum, just distal to the left subclavian artery.

TABLE I

PRINCIPAL MEDIASTINAL MASSES

A. Superior Mediastinum
 1. Thyroid
 2. Aneurysm
 3. Thymoma

B. Anterior Mediastinum
 1. Aneurysm
 2. Thymoma
 3. Teratoma
 4. Lymphoma
 5. Bronchogenic cyst
 6. Morgagni hernia
 7. Pericardial cyst
 8. Bronchogenic carcinoma

C. Posterior Mediastinum
 1. Aneurysm
 2. Neurogenic tumor
 3. Bronchogenic tumor

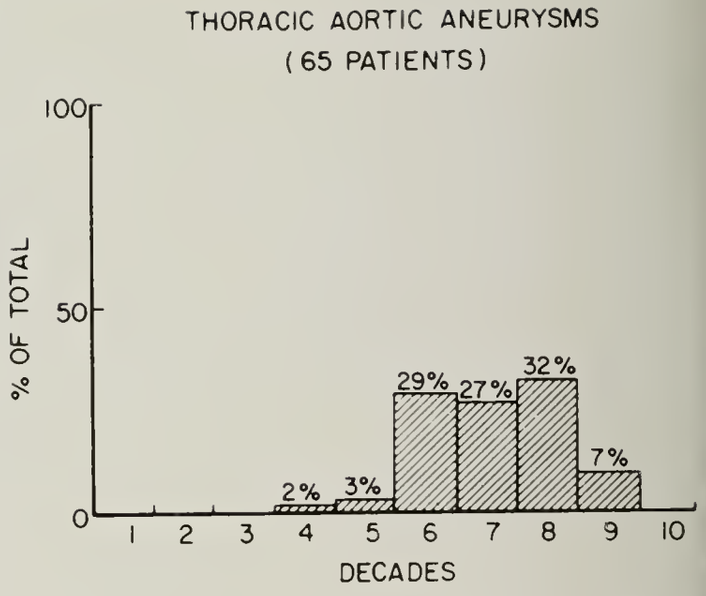


Figure 1. Age distribution of 65 patients with true or non-dissecting aneurysms of the thoracic aorta at University Hospital.

SURGICAL MANAGEMENT

The safe management of aneurysms of the thoracic aorta has long posed a major challenge to the cardiovascular surgeon. Fortunately, with careful planning and preparation these lesions can now be resected with a low mortality rate. In Figure 4 are shown the common locations of thoracic aortic aneurysms, and it is clear that when the vessels of the arch are involved, or when the ascending aorta is involved, or

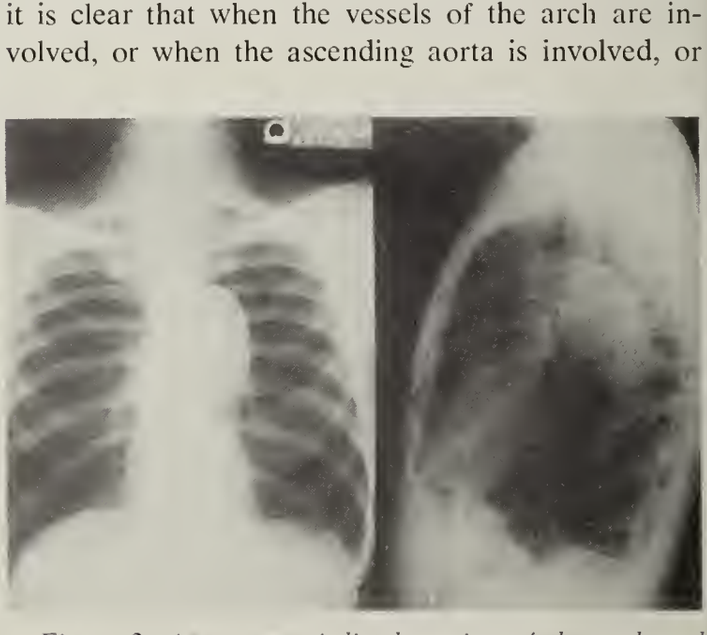


Figure 2. Aneurysm of distal portion of the arch and the first portion of the descending aorta. This lesion involved the left subclavian artery but not the left common carotid artery. It was resected using a bypass (see Figure 5) and replaced with a woven Dacron fabric graft (see Figure 8).



Figure 3. Aortogram confirming the diagnosis of aneurysm with respect to the lesion shown on plain chest x-ray in Figure 2.

when a thoracoabdominal aneurysm involves the celiac axis, superior mesenteric and renal arteries—in each particular instance special planning will be required to protect the heart, the brain, or other viscera or parts of the body during the period of cross-clamping of the aorta. This is readily achieved using a pump-oxygenator and total cardiopulmonary bypass, in the case of the ascending aorta and arch, or with the use of appropriate bypasses when the aneurysm involves the descending aorta (see Figure 5); in fact, some surgeons simply cross-clamp the aorta above and below an aneurysm of the descending aorta, without cooling the patient or placing a protective bypass with which to perfuse the body distal to the lesion. Aneurysms involving the thoracoabdominal aorta are also readily resected with appropriate planning (see Figure 6). The aneurysm is replaced with a fabric graft (see Figures 7 and 8). Occasionally a sacciform aneurysm has a "neck" that can simply be cross-clamped and oversewn, without interruption of blood flow through the aorta as is required for the resection of a fusiform aneurysm. However, great care must be exercised to avoid displacing thrombus which could embolize to distal parts of the body.

RESULTS

As noted previously, the results of resection of thoracic aortic aneurysms are now generally satisfactory. The vast improvement that has come about in recent years has been due largely to improvement in operative technique, particularly the avoidance of total body heparinization wherever possible and the use of teflon felt backing of the suture lines. These two considerations have reduced the mortality rate

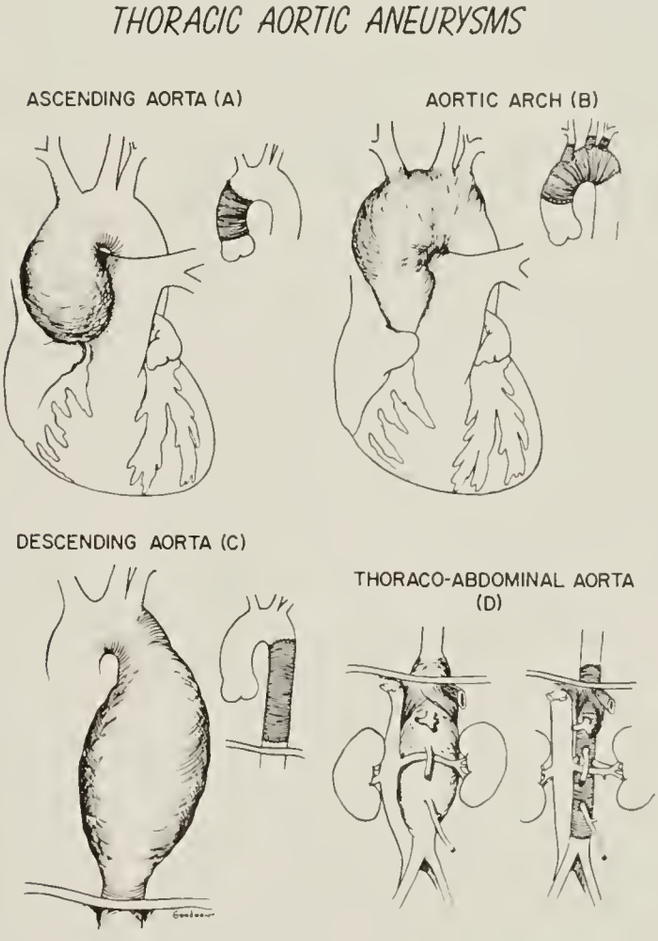


Figure 4. Sites of aneurysm formation in the aorta. A lesion in the ascending aorta, or in the arch, usually requires cardiopulmonary bypass for its resection. Exceptions to this are instances when a sacciform aneurysm can be excised with lateral suturing, and when a system of tube bypasses is used to resect an aneurysm involving the arch and great vessels, without interruption of perfusion of the brain and the rest of the body during occlusion of the aorta for resection of the aneurysm. The lesion of the descending aorta (c) could be resected by using an aortic bypass or, as some surgeons prefer, by simply cross-clamping the aorta without use of either bypass (see Figure 5) or hypothermia.

THORACIC ANEURYSM BYPASS

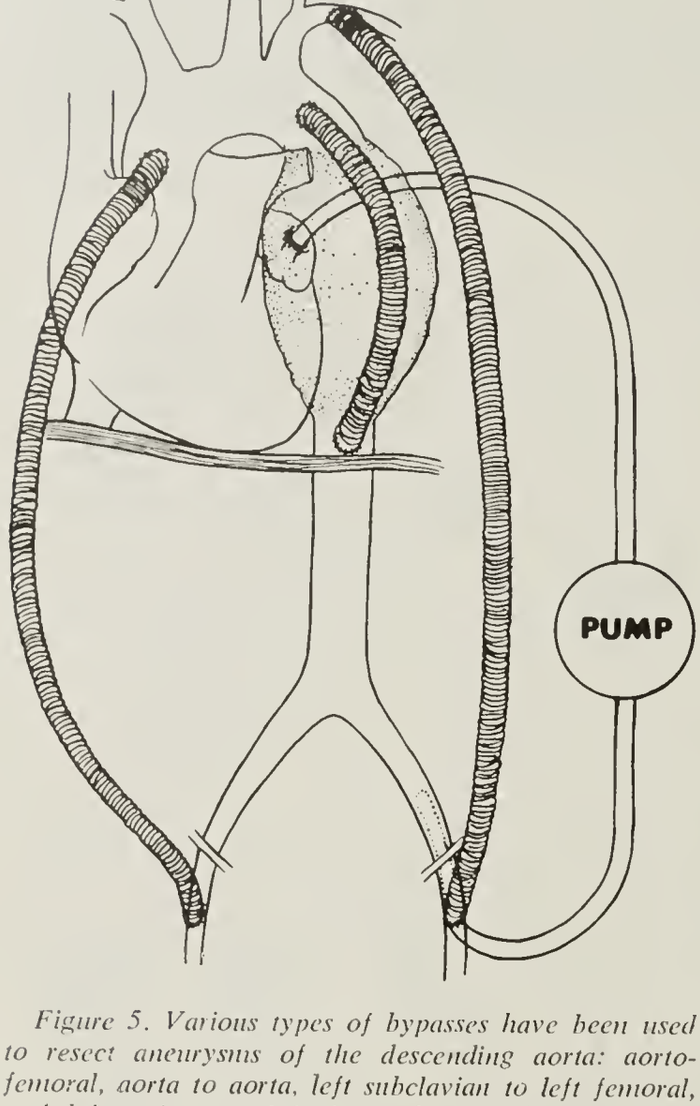


Figure 5. Various types of bypasses have been used to resect aneurysms of the descending aorta: aorto-femoral, aorta to aorta, left subclavian to left femoral, and left atrium to left femoral using heparinization and a pump. Some surgeons use no bypass, preferring simply to cross-clamp the aorta without the implied protection of a bypass to perfuse the body below the occluded aorta. We prefer a tube bypass, usually from the ascending aorta to a femoral artery, without heparinization.

in good risk patients to the quite acceptable level of about 10 per cent. Of course, when an expanding or leaking thoracic aneurysm must be resected in an elderly patient who has cardiac-pulmonary-renal disease, the complication and mortality rates will be higher.

SUMMARY

1. The thoracic aortic aneurysm is most often discovered on a routine chest x-ray. It is differenti-

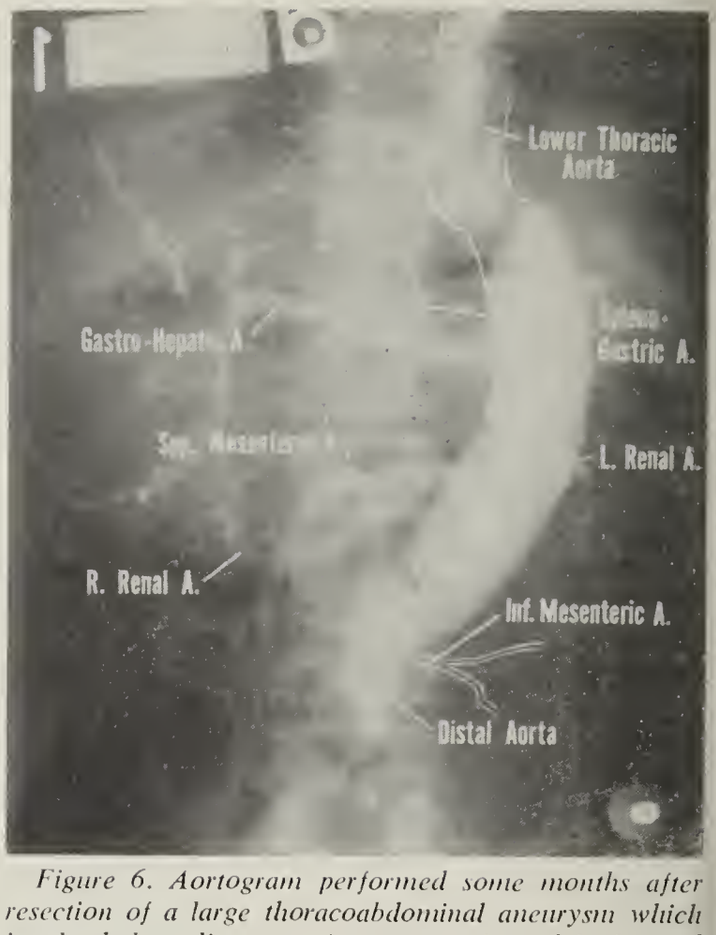


Figure 6. Aortogram performed some months after resection of a large thoracoabdominal aneurysm which involved the celiac, superior mesenteric and both renal arteries. (From Hardy, J. D., et al: Ann. Surg. 173: 945-65, 1971.)



Figure 7. Aneurysm shown in Figures 2 and 3.



Figure 8. Fabric graft replacement of aneurysm shown in Figures 2, 3, and 7.

ated from numerous other possible mediastinal lesions with aortography.

2. Most true thoracic aneurysms are due to atherosclerosis, a few to syphilis. Still other aneurysms may arise as the result of cystic medial degeneration, infection, trauma, dissection or even congenital factors.

3. The natural history of the thoracic aortic aneurysm is to expand, encroach upon surrounding structures and, in many instances, eventually to rupture as may abdominal aortic aneurysms.

4. Resection of thoracic aortic aneurysms now carries a low mortality rate in otherwise good risk patients. ★★★

Two drunks wandered into the world-famous San Diego Zoo and watched in awe as a lion let loose with a tremendous roar.

"Let's get outa here," said one drunk.

"You go, if you want to," said the other. "But I'm goin' to stay for the whole film."

Recurrent Radial Nerve Palsy

JAMES C. GROTTA, M.D.,* and
ANCEL C. TIPTON, JR.,† M.D.
Jackson, Mississippi

The radial nerve is very susceptible to injury and the typical Saturday night palsy (alcohol induced) is familiar to many physicians. Problems in diagnosis arise, however, when recurrent deficits occur. The authors present such a case report and also review motor unit involvement in Herpes zoster syndromes.

IT IS WELL KNOWN that the radial nerve due to its prolonged and tortuous course from the brachial plexus through the upper extremity is more susceptible to injury than the other peripheral nerves of the upper extremity. The typical Saturday night palsy is fairly familiar to all physicians in our alcohol prone society. Problems in diagnosis arise, however, when recurrent deficits occur such as in our present case.

CASE REPORT

A 55-year-old Choctaw Indian woman presented to the U. S. Public Health Service Indian Hospital, Philadelphia, Mississippi, on April 15, 1973. Her history revealed that in mid-December 1972, she developed the onset of "shingles" in a T-1 distribution on the left side. Within two weeks she had a sudden onset of a painless left wrist drop of classical type which did not resolve spontaneously. Previous history revealed the patient was known to be an abuser of alcohol and moonshine beverages. In 1968, she had the acute onset of a left radial nerve palsy which was felt to be traumatic (Saturday night palsy) in etiology. This improved over a two to three week period of time and returned to normal up until the recurrence in mid-December 1972. In October 1972, she was admitted for evaluation of abdominal pain. At that time a barium enema, upper GI series, liver function tests, serum amylase, and stool guaiac were all within normal limits.

On physical examination no abnormalities were noted in the head, neck, chest, heart, or abdomen. Neurological examination revealed normal cranial nerve functions and mental status examination.

There was a complete left wrist drop with no palpable or visible movement in the left brachioradialis, supinator, wrist extensors, or finger and thumb extensors. A depigmented scar with decreased sensation was present at the left shoulder region in the T-1 dermatome distribution. There was diminished sensation for pin-prick and light-touch in the distribution of the left radial nerve over the dorsum of the hand only. The deep tendon reflexes were 2+ and equal bilaterally. Extension of the forearm remained intact. No weakness or atrophy was present in the left triceps, deltoid, or teres minor muscles. Speech and cerebellar functions were within normal limts. No pathological reflexes were elicited. No lead lines, nail, or hair changes were present.

Present laboratory data revealed a normal chest x-ray and complete blood count with indices and smear. ANA, rheumatoid titers, B-12 levels, and a three hour glucose tolerance test were within normal limits. Electrolytes were within normal limits. A lead serum level was 18 micrograms per cent and the urine lead level was 19 micrograms per cent per 24 hours (both of which were within normal limits). Motor nerve conduction studies of the left median nerve and left ulnar nerve revealed normal distal latencies and velocities. Analysis of the usual "moonshine" imbibed by the patient revealed a 0 microgram per cent lead level, negative Arsenic, and heavy metal screen.

High dose multivitamin therapy failed to produce

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any improvement in her motor function. The patient then received a course of steroid treatment during a two week period in early May 1973, without any improvement in her radial nerve palsy.

Empirical treatment with EDTA, 1 gm. intravenously daily, for a five day period of time was carried out with simultaneous collection of 24 hour urine lead levels on the first day and last day of treatment. These urine lead levels revealed 24 micrograms per 24 hours and 17 micrograms for 24 hours respectively. Both of these values were well within normal limits and represent no significant increase over previous levels.

At the time of the last follow-up (July 1973) marked improvement of function in the left radial nerve distribution had occurred with absence of the previous wrist drop deficit. Thus the clinical course of this second episode of "radial nerve palsy" lasted six months before improvement.

DISCUSSION

In the presence of appropriate cutaneous manifestations, it is seldom difficult to decide whether segmentally distributed pain is a result of Herpes zoster infection. Less well known is the fact that motor neurons have no immunity to Herpes zoster infection. Muscle weakness of profound degree may be part of the Herpes zoster syndrome. The diagnosis, which at first seems so simple, may suddenly be in doubt when paralysis occurs weeks after the skin rash has subsided or when the weakness overlaps the boundaries of cutaneous segmental distributions. For unknown reasons, segmental Herpes zoster paralysis does not always coincide in location with the cutaneous eruption. Such topographic dissociation has been found to occur in less than 10 per cent of the cases and such was the case in our patient. Herpes zoster disease affects not only the sensory portion of the nervous system, i.e., dorsal horn, but also affects the motor portion, i.e., ventral horn as well. The reason some patients develop muscle weakness and others do not is unknown.

In a rather comprehensive study of segmental zoster paresis, Thomas and Howard[1] found 61 cases out of 1,210 patients with Herpes zoster to have segmental muscle weakness. These individuals always had motor manifestations preceded by cutaneous zoster manifestations with an elapse time ranging from less than one day to five weeks. Of the 61 patients, 28 had cranial nerve palsies. Facial nerve (VII) was most commonly affected in 23 of the 28. Upper limb muscles were involved in 16 cases with lower limb muscles in 15. Emphasis was placed on a favorable prognosis of segmental zoster paresis with complete functional recovery occurring in 55 per cent of cases and additional 30 per cent showing significant improvement. Severe and permanent residuals were more likely to occur in the distal rather than the proximal muscles.

Only the distal portion of the radial nerve was involved in the case reported suggesting either direct involvement of the peripheral nerve itself at the previous site of injury or possibly the deficit was greater and more consistent with dorsal root involvement prior to our examination. Motor involvement by Herpes zoster in Thomas and Howard's[1] review was predominantly of a radicular nature. The picture of a peripheral neuropathy such as in our case must be rare. Although there is always the possibility of another "Saturday night" to explain the recurrence of our patient's palsy, we believe the previous injury to her radial nerve predisposed her to Herpes zoster injury and also produced a prolonged course for complete functional recovery.

Increased frequency of or the dissemination of Herpes zoster occurs with inhibition of antibody production in diseases such as leukemia or lymphomas, irradiation, or prolonged steroid therapy. Thomas and Howard[1] found associated systemic diseases in 7 of their 61 cases (11 per cent) including co-existing malignant disease-lymphoma in 6 and chronic lymphocytic leukemia in 1. Malignant disease appears to be approximately three times higher in motor zoster than in cutaneous zoster—a useful observation to remember when trying to decide how far to go in the search for underlying malignant disease. No systemic disease has been demonstrated in the case reported. Other diseases included diabetes mellitus in three and histoplasmosis in one instance. Significant residual pain was experienced by 8 patients but was not present in our case.

Of the four clinical zosteric syndromes—encephalitis, myelitis, polyradiculoneuritis, and segmental radiculitis—only the last occurs with appreciable frequency as described by Broadbent[2] over 100 years ago. Segmental zoster motor paresis closely parallels that of cutaneous manifestations in that it predominantly strikes the middle aged and elderly. Certainly thoracic segment involvment is much more common than cranial nerve, cervical, or lumbosacral involvement. This is usually manifested primarily by sensory cutaneous zoster, although segmental weakness of intercostal and abdominal muscles could

easily pass unnoticed. Hogan and Krigman[3] recently reported a patient with ascending myelopathy proceeding to death with autopsy confirmation of direct viral invasion of the spinal cord without underlying malignancy. Their report speaks strongly against any postulated pathogenesis of an autoimmune mechanism in this central neuroaxis disorder.

SUMMARY

A 55-year-old woman with no underlying systemic disease, but with previous injury to her radial nerve, developed recurrent left radial nerve palsy following Herpes zoster infestation.

A review of motor unit involvement in Herpes zoster syndromes is discussed. ★★★

2500 North State Street (39216)

The authors wish to acknowledge the valuable contributions made by Dr. Arthur S. Hume, Assistant Professor, Department of Pharmacology and Toxicology, University Medical Center, Jackson, Miss. Toxicology Studies.

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—*Miss. Educational Advance*

Radiologic Seminar CXXXXVI: Renal Cyst Aspiration and Double-Contrast Study

J. V. FERGUSON, JR., M.D.
Greenwood, Mississippi

INCREASED USE of screening excretory urography in the past few years has resulted in the recognition of an increasing number of asymptomatic renal masses. Four to five per cent of the general hospital population can be expected to have asymptomatic space occupying lesions. The incidence rate in elderly adult males approaches 15 per cent. The vast majority of these asymptomatic masses are benign cysts.

In the past there has been a lack of confidence in radiographic diagnosis of renal mass lesions and surgery has been the method of choice. This method has resulted in a high rate of complications, lengthy convalescence, and high mortality rates in elderly patients (10 per cent for the 65-year group and 25 per cent for the 80-year group). Furthermore, an incidence rate of 11 per cent of unnecessary nephrectomies has been reported following exploration of benign renal cysts either because of uncontrollable hemorrhage or inability to confirm the benign nature of the lesion. In most cases of renal cyst surgical exploration is unnecessary and undesirable.

Because asymptomatic renal lesions are more frequent in elderly patients with their resultant higher mortality and morbidity rates, and because of the increasing frequency of discovery of these lesions it became necessary to find a method of investigation that would produce a highly reliable diagnosis with a minimum in cost, time, and risk for the patient.

This paper will be concerned with the diagnosis of cystic or avascular lesions. It is not intended to go into the various ramifications of diagnosis of solid or hypervascular tumors.

Our procedure is to follow the excretory urogram which demonstrates or suggests a mass lesion with a drip infusion nephrotomogram. The nephrotomogram is a relatively innocuous procedure and is readily available in most radiology departments. If the nephrotomogram demonstrates a solid, hypervascular or indeterminate lesion the next step is selective renal arteriography. However, if the lesion appears to be a cyst or if it is avascular, the next step is renal cyst aspiration and double-contrast examination. This technique of examination represents a



Figure 1. Excretory urogram in a 79-year-old white male reveals a large asymptomatic mass in the lower pole of the right kidney.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Leflore General Hospital, Greenwood, Miss.

multidisciplinary diagnostic approach. The aspirate is examined visually, histochemically, and histopathologically and the size and contour of the cystic mass are documented radiographically. This combination of diagnostic information will provide a diagnosis with a very high degree of confidence. Lang found cyst puncture, aspiration and double-contrast study of avascular renal masses to be 98 per cent accurate in patients with benign, multilocular, tumor-containing, inflammatory or parapelvic cysts, cystic hypernephromas and polycystic disease.

This examination requires no special patient preparation and no special instruments. It causes very little discomfort to the patient. After intravenous injection of 50 cc. of Conray the patient is placed in the prone position on the x-ray table. The cyst can then be outlined against the opacified collecting system. The appropriate puncture site is marked on the skin and the area is prepared with an antiseptic solution. A skin wheal is raised with 2 per cent Xylocaine and the subcutaneous tissues and muscular layers anesthetized. A No. 19 or 20 3½ inch short bevel spinal needle is then inserted through the muscular layers perpendicular to the cyst. When the needle has passed through the muscular layers the patient is instructed to stop breathing and the needle is inserted into the cyst. Tubing is attached to the needle and fluid is aspirated. About 25 per cent of estimated cyst volume is aspirated. The aspirate is examined visually for color and turbidity; histochemically for fat, protein, and lactic acid dehydrogenase; histopathologically for malignant cells.



Figure 2. A nephrotomogram demonstrates the mass to have cystic characteristics. The opacity at the inferior aspect of the mass is residual barium in the colon.



Figure 3. Double-contrast study (erect) demonstrates a large cyst with smooth walls and no tumor nodules. The aspirate was clear and slightly straw-colored. It did not contain malignant cells or fat and only a trace amount of protein.

The aspirated fluid is replaced with an equal amount of water soluble contrast material (Conray) and air. For best results the volume of air should be about twice the volume of water soluble contrast agent.

Radiographs are then exposed in various positions in order to view all the inner surfaces of the cyst. Care should be taken to superimpose the opacified cyst upon the nephrotomogram to account for the entire mass, exclude the presence of other lesions, and ascertain that the aspirate came from the lesion in question.

The aspirate from benign cysts is straw-colored and clear. Fat, protein, and lactic acid dehydrogenase are low. Smear and cell block are negative for malignant cells. Radiographs demonstrate a smooth inner lining of the cystic cavity.

Inflammatory cysts may contain clear or turbid and bloody aspirate. Fat and protein content are slightly elevated but the LDH content is markedly

elevated. Cell block is negative for malignant cells but some abnormal cells may be seen on the smear. The double-contrast study usually shows the inner lining of the cyst to be smooth but there may be some coating effect secondary to fibrin deposits.

Cystic or necrotic tumors usually have a bloody or murky aspirate with high fat and protein content but with low LDH. Cytological examination readily demonstrates tumor cells. The double contrast study of the cyst demonstrates tumor nodules projecting into the cyst lumen or irregular extravasation of contrast material in necrotic tumors.

Occasionally old blood is aspirated from a benign cyst which has bled. However, histochemical and histocytological examination should lead to the correct diagnosis.

Some surgeons object to the needle aspiration of malignant renal masses for fear of dissemination of tumor along the needle tract. This is probably negligible. von Schreeb and his co-workers compared five year survival of two groups of patients who were treated by nephrectomy for hypernephroma. In one group 77 patients had preoperative needle aspiration while 73 patients in the control group did not. There was no difference in the five year survival rates between the two groups.

SUMMARY

A rapid and relatively inexpensive method of evaluating renal masses with cystic or avascular characteristics is described. Diagnosis can be made with a high level of confidence. The procedure causes little discomfort to the patient. ★★★

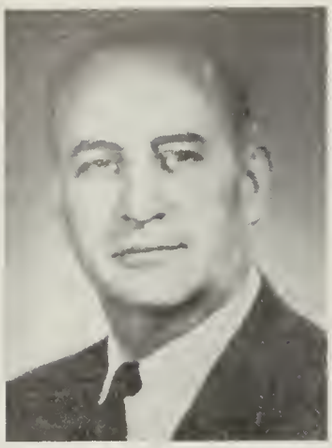
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INGREDIENTS FOR SUCCESS

If you can't eat the mustard, you'll never ketchup.



The President Speaking

"Season's Greetings"

J. T. DAVIS, M.D.
Corinth, Mississippi

As we approach the Holiday Season in these trouble-filled days of world strife, internal wrangling and political disputes let us turn our thoughts to the happy spirit of Christmas and to its sacred significance.

In celebrating this happy day, let our hearts be filled with gratitude for our many blessings and let us join with our fellow men in the spirit of giving and good cheer.

Too, as we near the end of this calendar year, the time to reflect upon our many deeds and actions, may we all be privileged to look back upon a happy and useful 1974, filled with memories of duties well performed.

This Christmas Prayer carries a significant meaning and clearly expresses my sentiments and best wishes to all.

A CHRISTMAS PRAYER

"Let us pray that strength and courage abundant be given to all who work for a world of reason and understanding; That the good that lies in every man's heart may day by day be magnified; That men will come to see more clearly not that which divides them, but that which unites them; That each hour may bring us closer to a final victory, not of nation over nation, but of man over his own evils and weakness; That the true spirit of this Christmas Season—its joy, its beauty, its hope, and above all its abiding faith—may live among us; That the blessings of peace be ours—the peace to build and grow, to live in harmony and sympathy with others, and to plan for the future with confidence."*

Merry Christmas!

* Courtesy of New York Life Insurance Company.

★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XV, NUMBER 12
DECEMBER 1974



EDITORIALS

"Think Cancer"

The steady rise in cancer mortality since 1900 is reflected in recent figures from the American Cancer Society with the number of annual deaths in this country approaching 300,000. While patterns and incidences of malignant disease vary with sex, age, and geographic location, all areas of this country are proportionately involved in this increase in tumor incidence.

For several years the American Cancer Society has promoted an intense campaign outlining the early signs of cancer in different body sites. This public information effort has been effective and the lay public is now more conscious of cancer.

Unfortunately, while the lay public has developed this increased awareness of malignant disease, medical education has lagged seriously in creating a cancer consciousness in medical students and practicing physicians. To note an improvement in the mortality figures all physicians must constantly think of cancer and screen all patients for malignant disease. Only through a constant awareness on the part of the physician will the symptomless patient be found at a potentially curable stage. Once malignant disease is suspected a careful, orderly, and discriminating work-up must be undertaken to establish the type of malignancy present.

Once a histologic diagnosis has been obtained, additional procedures are required to define the exact extent of the primary involvement, nodal disease, and distant metastasis with appropriate TNM system staging. Therapy should not be undertaken until these steps have been completed. Following appropriate therapy a period of close follow-up is mandatory. To accomplish the above, thereby benefiting all his patients, each physician must constantly THINK CANCER.

Myron W. Lockey, M.D.
Associate Editor
Jackson, Miss.

Professional Liability in Mississippi

The crisis in professional liability for the medical profession continues unabated with no satisfactory effective solution in sight. Escalating premium rates for professional liability insurance continue throughout the United States, particularly on the West coast, Northeast, and Midwest sections. The South continues to enjoy the lower scale and Mississippi occupies the enviable position of the forty-fifth state, in ranking states by rate level—the fourth lowest premium rate in the nation.

The experience rate in Mississippi has been most favorable during the past decade, such that the premium rates for the usual coverage have remained fairly stable as compared to other states. The premium cost as of this date for current class 1—$100,000/$300,000 is $117 as compared to California rate of $915 and Florida of $1,217.

Insurance executives contend the favorable influence on the continued low incidence of litigation in Mississippi may be attributed to "the careful program management by the Board of Trustees and the cooperation of the members of the Mississippi State Medical Association." For many years the Board of Trustees and general officers, acting as a review and advisory committee to those seeking help in cases of threatened, or actual litigation, have gained invaluable information and experience. This review has served to eliminate many of the nuisance threats that have appeared without merit. The trend toward increasing law suits or nuisance threat of litigation continues all over the nation and now appears to be bubbling over into Mississippi. If this trend continues, we can surely expect increasing premiums until some drastic and strong counteraction is provided by the federal government in cooperation with the medical profession.

Wherein lies the cause of this rapidly escalating

rate of legal entanglement by the members of the medical profession, and what can be done to attack the problems? Of recent years the malpractice muddle has attracted growing concern outside of the medical profession. Realizing that the state of affairs was affecting the quality of medical care to the public the federal government has shown some concern. There are those who have suggested a system of arbitration or a pre-determined schedule of limitation on jury awards; patient-paid malpractice insurance; and panels of physicians and lawyers to review potential malpractice cases before they go to court. (The latter procedure simulates the review mechanism used by the Board of Trustees of the Mississippi State Medical Association in cooperation with the insurance companies.)

Many of the facts gleaned from review by the Board of Trustees at the state level may be of considerable interest to our members and are presented here for information and guidance.

Factors encouraging litigation:

1. Insurance authorities state that a large percentage of litigation against members of the medical profession begin following a word or implied action of disapproval by some other medical colleague.
2. Incomplete and scanty records of hospitalization and operations, oftentimes illegible.
3. Summary of hospitalization being omitted from the record, or incomplete. The physician may overlook instructions for post hospital care and return visits.
4. Misunderstanding between physician and patient regarding permission for treatment and/or results to be expected from surgery or treatment. An informed consent document composed by the best of legal talent will not replace good rapport between doctor and patient. A patient's satisfaction with his doctor's personal communications are more important than the best signed document.
5. Frequent loss of doctor-patient relationship since the entry of the third party into the health care field. The doctor often finds himself striving to satisfy the rules and regulations of the insurance carrier, rather than the patient.
6. Lack of good rapport between physician and patient, many times because of personal feelings, prejudice, and/or indecision or haste on the part of the physician in dealing with the patient.
7. Carelessness on the part of the physician, or surgeon, in planning and executing appropriate procedures and treatment for each patient.
8. A suit-prone physician often takes on more work than he can adequately handle. This type of doctor is in trouble if he does not stop long enough to recognize his professional limitations.
9. The trend of the times toward increasing judgments awarded by the courts to the successful plaintiff, encouraging out-of-court settlements, many without merit.
10. The increasing vigilance on the part of the legal profession, hungry for the "fat fees" afforded by this lucrative field in medico-legal litigation.

What can the physician do to protect himself from these legal entanglements? The following are points of interest gleaned from experience at the state level and are offered as suggestions.

1. Every practicing physician and surgeon should carry adequate professional insurance. In the years past one hundred thousand and three hundred thousand dollars ($100,000/$300,000) coverage was considered to be adequate. Today in the light of current events, this is open to question and many are suggesting the million dollar coverage.
2. Avoid loose talk concerning your colleague, even though you may disapprove of his actions. Criticism should be avoided in most instances, and if warranted, should always be discreet. Remember you are also vulnerable and may have your day in court. Action on the part of the Professional Review System now being implemented in every hospital should be sufficient to dissipate this criticism.
3. Keep good legible records sufficiently ample to reflect diagnosis and your decision for appropriate treatment. Good records are the physician's best defense.
4. Explain carefully to the patient in the presence of a witness your anticipated procedure and treatment in detail, noting the unfavorable as well as the favorable sequelae.
5. Hospital records at the time of discharge should contain a summary of the pertinent findings, diagnosis, and treatment, in addition to the condition at the time of leaving the hospital. Last, but most important, specific instructions for care following dismissal from the hospital, as well as prescriptions given, should be recorded.

6. Know your limitations, and confine your professional activities within the bounds of your training and capabilities. When in doubt seek consultation. No one has ever been criticized for requesting help. In this way your consultant shares your responsibility and your patient is assured that you are trying to deliver the best of medical care available.
7. In most instances admitting one's mistake at the time, with honest information and adequate explanation to the patient and family, is far better than an attempt to hide the facts and avoid censure, only to become involved later in a legal battle with little defense for your actions.
8. Notify your professional liability insurance carrier and seek legal counsel early, when threatened with litigation.
9. Although most members of the medical profession carry professional liability insurance which is widely known to the public, it is the opinion of most insurance authorities that the amount of your coverage should be considered as confidential information between you and your insurance company. It is the opinion of many that your hospital is not privileged in this respect, and thus this information should be available to your hospital authorities only on advice of legal counsel.

The best postscript to a study of this sort is a quotation from the A.M.A. Law Division report submitted to the House of Delegates in San Francisco in June 1968: "Professional Liability is an occupational hazard which can be expected to become more acute for the physicians before the problem is eased."

Obviously, there are no easy solutions to the problem of malpractice litigation, but the present system isn't working and some radically new approaches are clearly indicated. It is a perplexing question of where these initiatives and innovations will come from—from within the medical profession or from without. To say the least, the problem deserves our close attention and continued efforts toward some reasonably satisfactory solution. If this is not forthcoming, the ravages of malpractice litigation will soon become an undesirable deterrent in the delivery of quality medical care to the public at a reasonable cost.

J. T. Davis, M.D.
President
Corinth, Miss.

MEDICAL DIRECTOR:

The Board of Trustees, Eleemosynary Institutions is seeking physician applicants for a full time position as medical director at each of the following state operated acute general hospitals.

South Mississippi State Hospital, Laurel, Mississippi; Kuhn Memorial State Hospital, Vicksburg, Mississippi; Natchez Charity Hospital, Natchez, Mississippi.

There would be no initial cost to the physician for equipment, office expenses, or secretarial expense. Annual income, $50,000. Physicians interested in these positions should contact the following board members: Joe M. Ross, M.D., The Street Clinic, Vicksburg; J. P. Tatum, M.D., 1314 19th Avenue, Meridian; Charles A. Hollingshead, M.D., 103 S. 12th Avenue, Laurel; John R. Young, M.D., 55 Sergeant Prentiss Dr., Natchez; O. B. Crocker, M.D., Bruce, or the Board's Office, 1404 Woolfolk State Office Building, Jackson, Mississippi 39201.

Medico-Legal Briefs

CONSENT AND INFORMED CONSENT

When one person touches, hits or makes contact with another person without their consent it constitutes, theoretically, a battery. Battery, as a legal term, encompasses all contacts between human beings which are neither consented to nor usually permitted by social custom.

An unauthorized touching or contact may constitute battery even without the element of intent to harm, primarily because our society views any such contact in the absence of consent as a breach of an individual's legal rights. Even if the outcome of the contact is beneficial it may be legally held a battery.

Physicians, in the exercise of their profession, must necessarily engage in numerous physical contacts with their patients. Since all of these contacts are with the patient's body, they could presumably constitute battery unless either the patient or the character of the situation itself has authorized the contact. This very often presents the physician with a potentially hazardous dilemma and it would be advantageous for every practitioner to thoroughly familiarize himself with the elements of a valid consent.

Generally, there may be said to be two types of consent—express and implied. An express consent occurs when a patient gives his consent orally or in writing for himself or his minor child, or when a guardian consents orally or in writing for an individual who is non compos mentis.

An implied consent may be granted by the conduct of the person seeking treatment, as when a patient rolls up his sleeve to receive an injection. Consent is also implied in an emergency situation. When a patient is in need of immediate treatment, but is physically or mentally unable to provide consent, the physician is considered to be justified in assuming he has the patient's consent and when the dangers occasioned by any delay in order to locate someone capable of consenting are imminent. Such consents are generally held to be "implied at law."

One important factor that the physician must always be aware of is the fact that a consent, whether express or implied, may not be deemed to be a valid one in the absence of an informed explanation to the patient of the particular treatment to be provided and any potential hazards which might result. This necessarily requires the application of that peculiar legalese, known as "informed consent," which often befuddles physicians.

The doctrine of informed consent is based on the premise that the patient has a right to know the facts affecting medical or surgical risks his physician advises him to undertake. Simply stated, a consent, in order to be legally valid, must be an intelligent and informed one, with an understanding of what is to be done and the risks involved. Legally, a physician has a duty to inform his patient about contemplated medical procedures and the inherent risks, and a breach of this duty prevents the patient from rendering an "informed consent" to the treatment.

Perhaps the most important element of an informed consent is the avoidance of using medical terminology the patient does not understand in explaining a particular treatment or procedure. Such explanations must be given in a way that the patient understands them. It is no defense to the physician to claim that he told the patient what he was going to do as long as he knew that what he was saying was "over the patient's head." For example in *Corn v. French* (289 p. 2d 173, Nev. 1955), the patient signed a consent for a mastectomy, but she did not know what the word meant. Her consent was, therefore, useless and of no defense to the surgeon. Basically, since each patient is different, the physician is obligated to pursue the requisite explanations until he knows that the patient, his family or both, understand clearly what is involved.

When a physician wishes to use a treatment method which entails certain risk factors and he knows that some alternative, less risky, treatment exists, he is obligated to advise the patient to that effect. The patient has the right to decide for himself which course of action, if either, he prefers. The failure to explain the existence of an alternative may be construed as negligence.

All too often many physicians rely *solely* on a written form signed by the patient as *the* consent. In some cases this is enough to constitute a valid consent for routine surgical procedures in which the permanent risks are negligible; but no physician should rely solely on such standard consents prior to initiation of a treatment plan in which the possibility of risks is inherent. Just as no physician should rely on a standard surgical consent form to meet the requirements that the patient have an informed consent, no signed writing or document, in and of itself, will always constitute an informed consent. It is important to remember that the best defense against a patient's charge that he did not give an informed consent is the doctor's rapport with his patient and his personal explanation of the mode of treatment together with any potential dangers or consequences associated therewith. Ideally, the scenario of an informed consent should go something like this: the doctor presents the standard surgical consent to the patient and says that it authorizes him to perform the surgical procedures noted thereon. He should explain what these procedures are, any consequences that may result, and any additional procedures which he feels might have to be done should some complications arise. For example, in the case of a cervical pregnancy the physician may only plan to do an abortion and dilatation and curettage; but if, after these two procedures have been done, the patient experiences severe bleeding he may have to do a hysterectomy although the possibility of having to do this in most cases is remote. Nevertheless, all the ramifications should be explained to the patient before the consent form is signed. In addition, for obvious reasons, it would be advantageous for the physician to have some third party, either a nurse or another physician, present during the course of his explanation.

Obviously, a problem very often arises when the physician has to consider, as he almost always does, the possible emotionally detrimental effect a detailed explanation might have on the patient. Should the patient be advised of all the gory details inherent in

his treatment? This is strictly a matter of medical judgment with the physician and the law has long recognized the physician's right to make that decision based on the best interest of the patient. In the case of *Berkey v. Anderson* (1 Col. 3d 790, 1969) the court said:

> . . . A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent . . .

If the patient is seriously ill and unduly apprehensive, the physician knows he may cause harm by elaborating on unexpurgated revelations of gruesome procedures to be performed in the future, and the law does not require him to do so. He must only do what is reasonable under the particular circumstances and exercise due care.

In conclusion, the physician must be prepared to prove that he explained the risks involved to the patient whenever surgical, therapeutic or diagnostic procedures involve more than the hazards which the patient might normally expect. The physician's best protection is to *personally* inform the patient fully regarding any unusual risks that may be involved and *then* to obtain a consent in writing in which the patient acknowledges the explanation.

WILLIAM F. ROBERTS, J.D.
Executive Assistant
MSMA

Is there a tablet containing *only* an expectorant and *only* Glyceryl Guaiacolate? YES!

1. Patient acceptable tablet dose.
2. Single entity expectorant.
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An identifiable white, scored tablet which significantly stimulates the secretion of respiratory tract fluid.

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Composition: Each sugar-free compressed tablet contains glyceryl guaiacolate 100mg. **Action and Use:** This preparation utilizes the effective expectorant action of glyceryl guaiacolate which significantly stimulates the secretion of respiratory tract fluid. The increased flow of less viscid fluid favors expectoration and has a demulcent effect on the tracheobronchial mucosa. The primary usefulness of Hytuss Tabs is to promote the change from a dry, unproductive cough to a productive cough. Hytuss is therefore useful in treating coughs due to the common cold, bronchitis, laryngitis, tracheitis, pharyngitis, influenza and the measles. The expectorant action of Hytuss may also provide symptomatic relief in some chronic respiratory disorders when the patient experiences spasms of dry nonproductive coughing. **Precautions:** Extremely large amounts may cause nausea and vomiting. **Administration and Dosage:** *Adults*—1 tablet four times daily. *Children*—6 to 12 years of age; ½ tablet 3 or 4 times daily. HOW SUPPLIED: White, scored, sugar-free, tablet in bottles of 100 - 1,000 - 5,000. **Product Identification Mark:** Hy. **Literature Available:** On request.

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Hyrex

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POSTGRADUATE CALENDAR

THE MISSISSIPPI POSTGRADUATE INSTITUTE IN THE MEDICAL SCIENCES

Jan. 27-31, 1975

EKG Intensive Course

University Medical Center, Jackson
Jan. 27-31, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
Thomas M. Blake, M.D., professor of medicine, the University of Mississippi School of Medicine

The course will consist of a series of discussions of selected topics in electrocardiography chosen on the basis of their immediate clinical applicability. Electrocardiograms, slides and other visual aids will be used, and participants will have the opportunity to interpret electrocardiograms, raise questions, and suggest specific topics for consideration. Interpretation of tracings will be emphasized.

Feb. 10-14, 1975

Urology Intensive Course

University Medical Center, Jackson
Feb. 10-14, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
W. Lamar Weems, M.D., associate professor of surgery and chief of the Division of Urology, the University of Mississippi School of Medicine

The course will emphasize practical urology as it relates to the non-urologist. The latest concepts and practices in common urologic diseases will be presented.

Feb. 17-21, 1975

Otolaryngology Intensive Course

University Medical Center, Jackson
Feb. 17-21, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
Godfrey E. Arnold, M.D., professor of surgery, director of the Division of Otolaryngology, and associate professor of physiology-biophysics, the University of Mississippi School of Medicine

This course will present a basic review of otolaryngology for the primary care physician, including office treatment, detection of complications, and overview of special services. This will include audiology, vestibular testing, speech and voice rehabilitation, allergies, and neurotology. Lectures, seminars, clinics, rounds, demonstrations, and surgical observations will be supplemented by assigned reading.

Feb. 24-28, 1975

Pediatrics Intensive Course

University Medical Center, Jackson
Feb. 24-28, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
J. M. Montalvo, M.D., professor of pediatrics and assistant professor of biochemistry, the University of Mississippi School of Medicine

Registrants will participate in intake and ward rounds, refresh their skills in such areas as scalp vein techniques, use of the respirator, nebulizer and humidifier, and attend lectures on such subjects as fluids, hematology, cardiology, immunizations, allergies, seizures, pediatric emergencies, pediatric surgery, renal problems, and the care of the newborn. Round table discussions will include pediatric problems.

Mar. 3-7, 1975

Hematology-Oncology Intensive Course

University Medical Center, Jackson
Mar. 3-7, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
Francis S. Morrison, M.D., associate professor of medicine and director of the Division of Hematology, the University of Mississippi School of Medicine

Recent advances in oncology, as well as the basics of diagnosis and therapy, will be presented. Supportive management such as advances in component and problems of infection in immunosuppressed patients will be emphasized. Newer developments in hematology will also be covered.

Mar. 13-15, 1975

SURGERY FORUM

The Jackson Hilton Hotel
Mar. 13-15, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education and the School of Medicine Department of Surgery

Coordinators:
James D. Hardy, M.D., professor of surgery and chairman of the department, the University of Mississippi School of Medicine
William O. Barnett, M.D., professor of surgery, the University of Mississippi School of Medicine

This second annual three-day surgery conference features latest advances in surgical procedures. Lectures will cover gastrointestinal, endocrine, colon, pancreas, and breast surgery. Attendance is by invitation, and advance registration with fee of $150.00 is required. The fee is refundable prior to Feb. 14, 1975.

Mar. 20-22, 1975

NEUROLOGY-NEUROSURGERY INTENSIVE COURSE

University Medical Center, Jackson
Mar. 20-22, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinators:
Robert D. Currier, M.D., professor of medicine (neurology) and chief of the Division of Neurology, the University of Mississippi School of Medicine
Glen C. Warren, M.D., assistant professor of neurosurgery, the University of Mississippi School of Medicine

This two-day course will be didactic in format with opportunities for the participants to discuss the problems primary care physicians most often encounter in their practices. Head injury, the dizzy patient, headaches, epilepsy, sciatica, strokes, and tumors will be discussed in relation to adult and pediatric neurology and neurosurgery.

Mar. 24-28, 1975

CARDIOLOGY INTENSIVE COURSE

University Medical Center
Mar. 24-28, 1975

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education with support from the Mississippi Regional Medical Program

Coordinator:
James R. Galyean, M.D., assistant professor of medicine, the University of Mississippi School of Medicine

The course will familiarize physicians with current concepts in bedside diagnosis of heart disease. Practical points in physical diagnosis and in review of the various forms of heart disease will be covered using such aids as pulse tracings, phonocardiograms, electrocardiograms, x-rays, and hemodynamic data in illustration. Participants will round, observe cardiac catheterizations, and enter into team discussions on patient management. Reasons for suggesting or rejecting surgery will be discussed in detail. A cross-section of cardiac diagnoses will be reviewed.

FUTURE CALENDAR

Mar. 1975
NEONATAL WORKSHOP

May
FAMILY PRACTICE REVIEW

May 5-8
MISSISSIPPI STATE MEDICAL ASSOCIATION, BILOXI

Spring
RENAL SEMINAR

Fall
DIABETES SEMINAR

All intensive courses are offered through the University of Mississippi Medical Center, with partial support from the Mississippi Regional Medical Program, pharmaceutical firms, volunteer health agencies, and private donation. The courses are open to all Mississippi physicians. A registration fee of $100.00 is charged for each.

NEW MEMBERS

BURROW, REX LAMAR, JR., McComb. Born Memphis, Tenn., Feb. 26, 1938; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1964; interned, same, one year; pathology residency, same, 1967-71; elected by South Central Medical Society.

FORSTNER, JAMES ROBERT, Centreville. Born Van Nuys, Calif., Jan. 9, 1947; M.D., University of North Carolina School of Medicine, Chapel Hill, N. C., 1973; interned Los Angeles County Hospital, one year; elected by Amite-Wilkinson Counties Medical Society.

JACKSON, A. JERALD, Hattiesburg. Born Tippah County, Miss.; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1964; interned Wilford Hall USAF Hospital, San Antonio, Tex., one year; internal medicine residency, same, 1966-69; elected by South Mississippi Medical Society.

MCMILLAN, FREDERICK L., Jackson. Born Carthage, Miss., Jan. 15, 1943; M.D., University of Mississippi School of Medicine, Jackson, Miss., 1967; interned, same, one year; ophthalmology residency, same, 1967-68; ophthalmology residency, Tulane, New Orleans, La., 1970-71; Bacom Palmer Eye Institute, 3 months; elected by Central Medical Society.

SMITH, RALPH A., JR., Jackson. Born Knoxville, Tenn., Feb. 6, 1942; M.D., University of Tennessee College of Medicine, Memphis, Tenn., 1966; interned Baptist Memorial, Memphis, Tenn., one year; radiology residency, Mayo School of Medicine, Rochester, Minn., 1968-70; radiology residency, University of Kentucky, Lexington, Ky., 1971-74; elected by Central Medical Society.

DEATHS

None reported this month.

SCHEDULE FOR UPCOMING NCME PROGRAMS

Here are the playing dates and upcoming programs to be distributed by the Network for Continuing Medical Education (NCME):

Dec. 2-Dec. 15

Sex in Aging and Disease, with Philip A. Sarrel, M.D., Associate Professor of Obstetrics and Gynecology at Yale University Medical School, and Lorna Sarrel, Co-Director, Human Sexuality Program at Yale University Student Mental Hygiene Department, New Haven, Conn.

Medical Advances Institute, with James L. Henry, M.D., President of the Ohio State Medical Association; Paul Y. Ertel, M.D., Director of the MAI Clinical Systems in Ohio; William A. Millhon, M.D., Chief Physician Advisor, Riverside-Methodist Hospital, Columbus, Ohio.

Female Stress Incontinence: Diagnosis and Decision, with Vincent J. O'Conor, Jr., M.D., Professor of Urology, Chairman, Department of Urology, Northwestern Memorial Hospital, Chicago.

(Program scheduling subject to change)

For more information about NCME, write the Network for Continuing Medical Education, 15 Columbus Circle, New York, N. Y. 10023.

Book Reviews

Cardiac Arrest and Resuscitation. Fourth Edition. By H. E. Stevenson, Jr., M.D. 907 pages with 379 illustrations. St. Louis: The C. V. Mosby Company, 1974.

This text is a multiauthored volume written to cover all aspects of cardiac arrest and resuscitation although the attention given to each aspect of this important problem is quite variable. The chapter on prevention of cardiac arrest is particularly outstanding as are the basic chapters on the methods of cardiac resuscitation. Practical considerations are given to the geographical arrangement of resuscitation equipment within and outside the hospital (such as a football stadium). In this day and age the chapters covering the legal definition of death and consequences of resuscitation are quite pertinent. Resuscitation of special groups such as the near drowning patient and those involved in electrical mishaps are well handled and emphasize the importance of proper care in these situations. The chapter dealing with the electrical hazards of equipment within the hospital setting is especially good and should be required reading for physicians and hospital administrators alike.

By necessity, in a text such as this, the interest of the editor modifies the space given the various subjects. Acute myocardial infarction is hurriedly covered and there is inadequate correlation between anatomical site of infarction and probability of arrest and/or chances of successful resuscitation. The meager attention given cardiogenic shock which has become the major cause of in-hospital death following myocardial infarction is unfortunate but perhaps outside the scope of this text. As befalls any textbook the publishing process is laborious enough that by the time the book reaches its audience much of what it has to say is outdated. This book is no exception as exemplified by the chapters on balloon assist and the "stone heart syndrome." The former is incomplete and suggests that intra-aortic balloon may be a definitive therapy for the shock syndrome whereas recent data suggests that the balloon, although very effective in temporary relief of the shock syndrome, must be accompanied by a more definitive procedure such as coronary surgery to salvage the majority of the patients. The stone heart syndrome has hopefully now been relegated to medical history.

This book overall, however, can be recommended as an excellent reference book in the field of cardiac resuscitation and has information that would be of interest, not only to the family practitioner, but to the majority of specialists. This book would, in addition, be an excellent reference to have in the emergency units of most community hospitals.

H. Davis Dear, Jr., M.D.
Jackson, Miss.

Handbook of Medical Treatment. Fourteenth Edition. By Milton J. Chatton. 612 pages. Los Altos: Lange Medical Publications, 1974. $7.50.

There is indeed a wealth of information available in the new fourteenth edition of Dr. Chatton's handbook. The fact that it has gone into 14 editions would indicate that it has fit into the jacket pocket of many an intern over the years and will continue to do so, its 10½ × 17½ cm proportions being admirably suited for this purpose, as well as its contents.

Inevitable comparisons will be made with the "Merck Manual," that ubiquitous reference mainstay of thousands of GPs like myself. I find the absence of an adequate indexing system cumbersome and time-consuming, but perhaps familiarity and frequent usage would overcome this lack. Admittedly, topic selection must be limited in a volume of this character, but I find that many so-called minor conditions have been omitted. For example, under "Diseases of the Anus" only hemorrhoids is discussed. After 35 years of dealing with this interesting aperture, I can assure the budding practitioner that he will have to deal with many problems of the nether region other than hemorrhoids. Such minor omissions are well counterbalanced by complete and detailed treatment schedules of the major conditions, namely the sections on cardiovascular disease and diabetes in particular.

A particularly welcome facet is the usage of proprietary drug names throughout. Many a trip to the PDR will thus be obviated. I would recommend the handbook to practitioner and student alike as a concise source of up-to-date therapeutic regimens.

A. A. Derrick, Jr., M.D.
Durant, Miss.

PERSONALS

THOMAS J. ANDERSON and CECIL T. WILLIAMS of Laurel have been appointed to the Board of Laurel General Hospital.

GODFREY E. ARNOLD of Jackson and UMC gave two courses at the annual session of the American Academy of Ophthalmology and Otolaryngology at Dallas in October.

New board members of the Hinds County Unit, American Cancer Society, are FRANK R. BANKS, B. T. HICKMAN, TATE THIGPEN, and FRANK HOWELL. EDWARD LOWICKI serves as chairman of the professional education committee.

Medical members of the board of the Mississippi Division, American Cancer Society, were elected at the annual meeting in Jackson. They are: WARREN N. BELL of Jackson, NORMAN C. NELSON of Jackson, MARIAN GODBEY of Aberdeen, EDWARD LOWICKI of Jackson, JAMES P. SPELL of Jackson, FRANK WOOD of Jackson, WALTER ROSE of Indianola, ARTHUR DERRICK of Durant and MICHAEL JABALEY of Jackson.

RICHARD L. BLOUNT, ROBERT E. BLOUNT and JEANETTE PULLEN, all of Jackson, were featured in Millsaps College's *Major Notes* article on Millsaps Alumni in Medicine.

WILLARD BOGGAN of Jackson was guest speaker on coronary heart disease at the Senior Citizens meeting of St. James' Episcopal Church.

RICHARD G. BURMAN of Gulfport was awarded honorary membership at the convention of the American Association of Medical Assistants in Denver in recognition of his six years of service to the organization. Dr. Burman has now resumed his practice at the Woman's Clinic, 1213 Broad Avenue.

CARLOS M. CHAVEZ announces the establishment of his practice in cardiac, thoracic and vascular surgery at the University of Mississippi Medical Center with offices in the Department of Surgery.

ALTON B. COBB of Jackson has been appointed to serve on the National Advisory Council on health manpower shortage areas by HEW Secretary Caspar Weinberger.

MARION COCKRELL and ROBERT SCHMIDT announce the opening of new offices for the practice of obstetrics and gynecology at Hospital Medical Park on Vancleave Road in Ocean Springs. They will also maintain their former office at Schmidt Clinic in Biloxi.

ROBERT D. CURRIER and ARMIN F. HAERER of Jackson and UMC presented papers at the Central Society for Neurologic Research Convention at Grafton, Ill.

CLIFTON B. DAVIS is clinical director of the Gulf Coast Mental Health Center at 4514 Old Pass Road in Gulfport.

Governor William L. Waller has appointed J. T. DAVIS of Corinth and JAMES B. MARTIN of Monticello to the State Health Planning Advisory Council of the Division of Comprehensive Health Planning. AUBREY V. BEACHAM of Magnolia, who has been a member of the council, was reappointed for another term.

H. B. DEARMAN announces the opening of his office for the private practice of psychiatry with office located on Highway 30, Route 2, Etta.

A. ROBERT DILL of Columbus, president-elect of the Mississippi Society of Internal Medicine, represented Mississippi internists at the interim meeting of the American Society of Internal Medicine held Oct. 3-5 in New Orleans.

CHARLES FLOYD of Gulfport participated in a special television show on the coast in conjunction with the American Cancer Society, Harrison County Unit, concerning cell study and research.

THOMAS HOWARD GANDY of Natchez was among speakers at the first annual Antiques Forum of Natchez.

C. E. GRISSOM, PHILLIP POLLNER, ANIL GUPTA and VEENA GUPTA announce their affiliation for the practice of medicine and surgery as the Newton Medical and Surgical Group at 1011 South Main Street. Dr. Grissom will practice medicine and surgery; Dr. Pollner, internal medicine, cardiology and adolescent medicine; and the Drs. Gupta, general practice.

FRANK G. GRUICH of Biloxi has been appointed to the advisory board of First Mississippi National Bank.

D. STANLEY HARTNESS of Kosciusko and JOSEPH C. HILLMAN of Brookhaven have been selected as participants in the Mississippi Economic Council's Human Resources program for the year.

JAMES D. HARDY of Jackson and UMC addressed the luncheon meeting of the Mississippi Heart Association in Tupelo on "coronary bypass surgery."

MARY E. HAWKINS of Jackson announces the removal of her office for the practice of obstetrics and gynecology to 1037 N. Flowood Drive, Suite 2.

MICHAEL HOWE announces the opening of his practice in obstetrics and gynecology at Medical Arts Clinic, 517 University Drive in Starkville.

HERMAN KELLUM and BRIGGS HOPSON of Vicksburg are instructors for an emergency medical technology course sponsored by Hinds Junior College in cooperation with the Vicksburg Fire Department and West Mississippi Medical Society.

JOHN R. LAIRD announces the removal of his office to 1100 South Main in Newton.

RONALD R. LUBRITZ of Hattiesburg has been awarded first place in the 10th annual CUTIS manuscript contest for a research article. Dr. Lubritz's article was entitled, "Nodular Fascilitis."

NORMAN NELSON of Jackson and UMC was the featured speaker for the afternoon session of the Mississippi Division, American Cancer Society, annual meeting in Jackson.

PATRICK PIERCE of Gulfport was elected chief of the medical staff at Memorial Hospital for 1974-75. JOHN E. WILLIAMS was elected vice-chief and ANDREW K. MARTINOLICH is secretary.

LINDSEY RISHER and Mrs. Risher were honored with a reception by Gov. Bill Waller as part of retirement ceremonies for the director of the Governor's Office of Comprehensive Health Planning. Waller presented the "Outstanding Mississippian" award to Risher for his 36 years of continuous service to the state.

JOHN RUSSELL of Gulfport has joined the staff of the Veteran's Administration Alcoholic Treatment Center.

EDSEL F. STEWART of McComb has an exhibit of his paintings in the Eva Vernon Room of the Lincoln County Public Library.

Members of the Mississippi Advisory Council on Drug Misuse are JAMES SUESS and REGINALD P. WHITE of Jackson, W. L. JAQUITH of Whitfield and JAMES CHAMPION of Meridian.

BRUCE M. SUTTON announces the relocation of his office for the practice of psychiatry to 1050 Riverside Plaza, Lakeland Drive East in Jackson.

JAMES E. WADLINGTON announces the removal of his office for the practice of surgery and gynecology to Suite 506, Medical Tower, 440 E. Woodrow Wilson Drive in Jackson.

R. D. WARD announces the opening of his office for the practice of general and family medicine at 102 Medical Arts Center in Pascagoula.

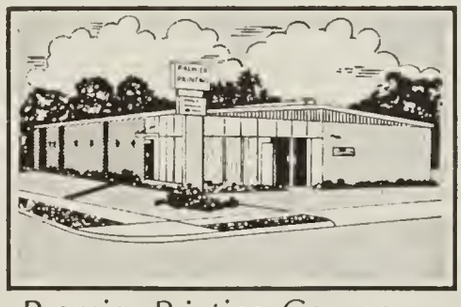
PAUL W. WARRINGTON and DONALD J. BLACKWOOD announce the opening of their practice of family medicine at Family Medical Clinic, 803 First Street in Cleveland.

W. L. WEEMS of Jackson and UMC participated in a planning session at the American Urological Association Allied Interim Meeting in Chicago.

Presented past president's pins at the annual meeting of the Mississippi Division, American Cancer Society, were: FRANK A. WOOD of Jackson, LOREN BRELAND of Crystal Springs, WARREN N. BELL of Jackson, D. S. PANKRATZ of Oxford and JAMES P. SPELL of Jackson.

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MEETINGS

NATIONAL AND REGIONAL

American Medical Association. Annual Convention, June 15-19, 1975, Atlantic City, N.J. Clinical Convention, Nov. 29-Dec. 4, Honolulu. Ernest B. Howard, Executive Vice President, 535 N. Dearborn St., Chicago, Ill. 60610.

Southern Medical Association. 69th Annual Scientific Meeting, SMA. 2601 Highland Ave., Birmingham, Ala. 35205.

Southeastern Surgical Congress, 43rd Annual Assembly, Feb. 17-20, 1975, Hyatt Regency Hotel, Atlanta. Preceded by postgraduate course, "Cancer of the Breast," Feb. 16.

STATE AND LOCAL

Mississippi Academy of Family Physicians, Annual Meeting, July 9-12, 1975, Biloxi. Mrs. Alyce Palmore, Executive Secretary, P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 107th Annual Session, May 5-8, 1975, Biloxi. Charles L. Mathews, Executive Secretary, 735 Riverside Drive, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Field Clinic, Centreville 39631. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, March, May, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Max Pharr, Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Smith, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson. 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Gerald A. Smith, Secy., P.O. Box 128, Sumner 38957. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. J. H. Gaddy, Secy., 4502 15th St., Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. Reginald P. White, Secy., East Mississippi State Hospital, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, April, June, August, October, December, Eola Hotel Roof, Natchez. Walter T. Colbert, Secy., Jefferson Davis Memorial Hospital, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. W. A. Brown, Jr., Secy., Mathiston Clinic, Mathiston 39752. Counties: Attala, Carroll, Choctow, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. S. Jay McDuffie, Secy., Nettleton 38858. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 1004 Jackson Ave., Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. G. Spencer Barnes, Secy., P. O. Box 1049, Columbus 39701. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, January, March, May, July, September, November. Thomas R. Singley, Secy., Doctors Plaza, Suite 208, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. John L. Smith, Secy., No. 1 Medical Blvd., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne.

West Mississippi Medical Society, 3rd Monday, January, March, May, September, October, November, 6:30 p.m. Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

The State Board of Health Reports on Activities During 1973-74

Fiscal Year 1973-74 was one of the most productive years ever for the State Board of Health and local county health departments in rendering service to Mississippians, according to Dr. Alton B. Cobb, State Health Officer.

"It was an exceptionally productive year for all phases of public health work in Mississippi," Dr. Cobb said. "It was also a year of change and redirection for the State Board of Health, with organizational revisions initiated to build a more efficient operating base, with changes in program structures and additional emphasis placed on the delivery of direct services to Mississippians."

He indicated that total agency funding was increased from $18,878,472 during FY1972-73 to $23,302,774 during FY1973-74.

"We're very fortunate in Mississippi to have state legislators who are interested in the health care of our state's citizens and it is primarily through their concern, hard work, and cooperation, that we can report such a successful year for public health work in the state."

According to Dr. Cobb, divisions and units at the state level were regrouped and structured into eight bureaus. Plans were also implemented to create eleven district offices following the Governor's Planning and Development Districts. When fully operational, these district offices will insure a more effective and efficient delivery system.

"Last year saw an expansion of our maternal and child health program through new federal appropriations and the development of a program of projects requiring each state MCH Program to have demonstration projects including maternal and infant care, intensive newborn care, children and youth, family planning, and dental services," he said.

"We also saw the expansion of our family planning program with 74,000 women now enrolled," he added. "We saw a continued fall in the birth rate associated with the expanded family planning program; a management study of our Crippled Children's Services, and additional state funding for cystic fibrosis and hemophilia programs."

He noted that through the venereal disease program, 11,839 persons were treated for gonorrhea and 628 persons were treated for syphilis throughout the state.

The Public Health Laboratory continued to provide laboratory services at a lower unit cost than any of Mississippi's neighboring states and the laboratory processed almost one million specimens last year.

"Another important area of work was in our solid waste program," he said. "Projects have already been established in 14 counties with 20 additional counties awaiting equipment. And, of course, the Bureau of Environmental Health continued their regular sampling and testing of public water supplies, milk products, and Gulf Coast seafood."

"One of the largest and most productive programs maintained was the home health program in which patients are provided home nursing care," he said. "Last year the 349 public health nurses throughout the state made approximately 50,000 skilled nursing visits to home health patients in addition to their regular work in other ongoing health department programs."

The State Board of Health and the Bureau of Licensure and Certification were given new authority to include standards for ambulances and training of emergency medical technicians for Emergency Medical Services. Some 843 child care facilities were licensed; 186 received initial licenses; and 211 were closed. Licenses were granted to 142 qualified nursing care facilities and 354 health care facilities including home health agencies, independent laboratories, and rehabilitation centers. Some 282 medical

licenses were issued bringing the total licensed physicians to 2,079—a net gain of 44. Three medical licenses were suspended and/or revoked.

"We also saw the creation of the new Mental Health Agency by the State Legislature," he said. "During the last year that our agency operated field mental health clinics, 8,644 patients received direct service."

"In the area of administrative services, a computerized payroll system was developed, a computer system for family planning data was initiated as well as a central computer listing of all foodhandling establishments in the state," he added. "More than seven million vital records are on file dating from 1912 and in an effort to reduce storage and provide faster retrieval service, the microfilming of these documents is currently underway."

"Although this is by no means a total picture of our activities during last year, the information provided does give an overall view of the agency's work," he added.

"We're proud of the work that we have accomplished during the past year," said Dr. Cobb. "And we hope to continue the expansion of services to Mississippians during the next year."

State MDs Attend Postgraduate Courses



Participants in the EKG one-week intensive course at the University of Mississippi Medical Center included, from left, Dr. Frank C. Wade of Magee, Dr. Robert T. Cates of Jackson, Dr. Will P. Thompson of Yazoo City (seated), and Dr. Judson Lloyd of Natchez. They discussed principles, techniques, and breakthroughs in EKG. The Academy of Family Physicians approves postgraduate credit for full attendance.

Area MPAC Legislative Seminars Set

The Mississippi Medical Political Action Committee (MPAC) has scheduled three regional "legislative and candidate support seminars" in December for members of MPAC, the assocation's legislative contact committee, and the Board of Trustees and general officers of the association.

The seminars will be held in Oxford on Dec. 2, Jackson on Dec. 11, and Hattiesburg on Dec. 16. Each program will concentrate on such subjects as the association's 1975 legislative program, the importance of candidate support, and effectively communicating with your legislators.

Each seminar will also include a fellowship hour and dinner at which featured speakers will address the subject, "Outlook for the 1975 Legislative Session." Registration fee for the seminars is $5.00 per person.

Regional Ambulance Service Advocated

The Emergency Medical Services (EMS) Division of the Mississippi State Board of Health and the new state EMS Advisory Council have recommended a multicounty regionalization of ambulance service as one practical way of designing manageable emergency medical services to areas where service is nonexistent or inadequate, according to Wade Spruill, director of the division.

"Regionalization means a system which provides for the arrangement of personnel, facilities, and equipment for the coordinated delivery of health care services in a designated geographical area under emergency conditions," Spruill said. "Supervisors of one or more counties and the governing authorities of municipalities may act jointly to provide emergency hospital care and ambulance service," he said. "This can be done by contracting with existing emergency services, where these services are adequate and bringing them together under a regional system."

The federal EMS Act of 1973 clearly encourages

the inclusion of rural areas in the development of regional plans. The Division of EMS (Mississippi) recommends that county and multicounty regions with inadequate service design an EMS plan which can be implemented without federal funds. The decision of county supervisors, hospital administrators, health care providers, consumers, and other public officials, then, is what level of service they are willing to support, either through direct ownership or on a contract basis.

"If a county or city should wish to investigate the regionalization of emergency medical services, they should contact the Emergency Medical Services Division of the State Board of Health in Jackson," Spruill said. "Also, personnel of existing regional planning authorities have expressed a willingness to assist officials in drawing up their plans. Improvement of emergency medical care is a community responsibility and should involve everyone."

Louisiana, Mississippi Internists Plan Meet

Specialists in internal medicine and related medical fields will hold a two-day scientific meeting on Jan. 24-25, 1975, at the Chateau Motor Hotel in Shreveport, La.

The Louisiana/Mississippi Regional Meeting of the American College of Physicians (ACP) is designed to bring physicians up-to-date on late developments in the field of internal medicine. It is one of more than 30 such sessions held each year throughout the United States, Canada and Mexico by the 30,000-member medical specialty society.

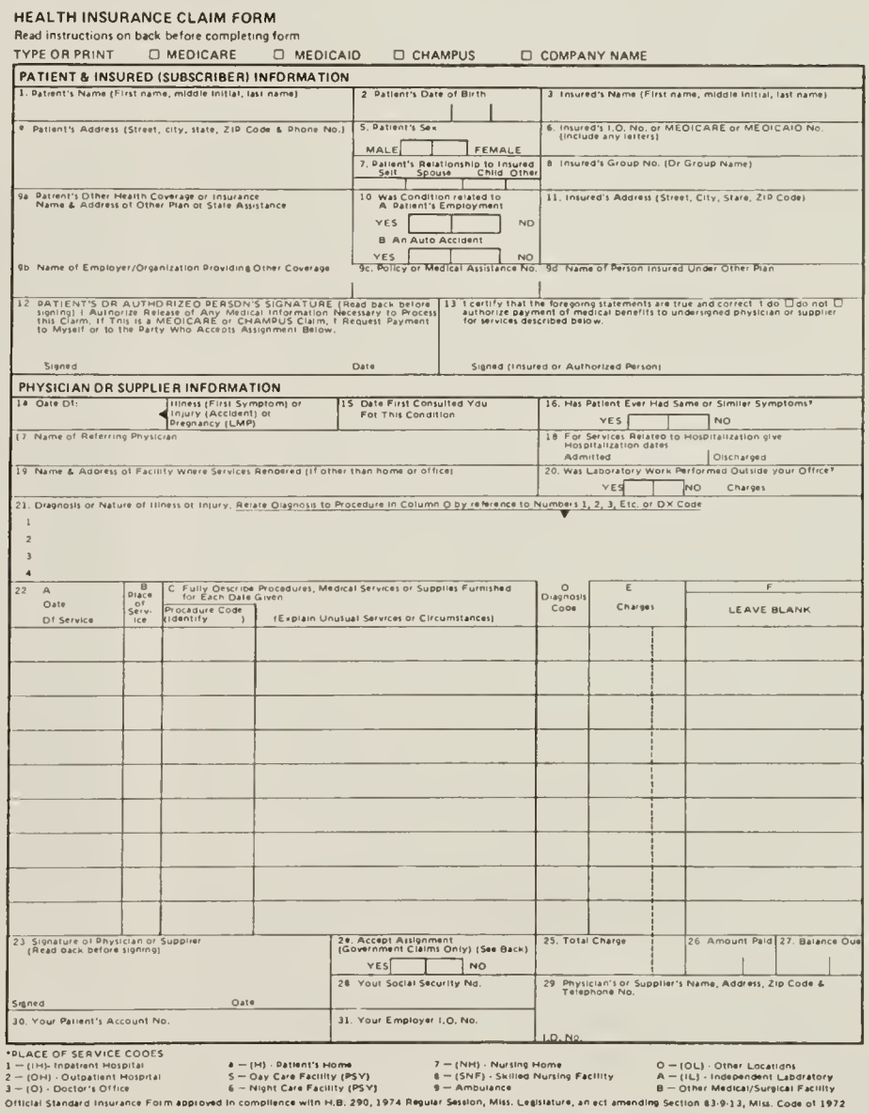
In charge of arrangements for the Louisiana/Mississippi Regional Meeting is Dr. Marion D. Hargrove, Jr., of Shreveport, who serves as the ACP's representative in Louisiana.

Mississippi Implements Uniform HCI Form

This month Mississippi will become the second state in the country to require a uniform health insurance claim form for physician services.

In a letter to all health insurance companies in September, State Commissioner of Insurance Evelyn Gandy gave 90 days notice of promulgation of a uniform claim form pursuant to the provision of House Bill 290, Laws of the 1974 Legislative Session. Detailed information about the new claim form has been sent to each physician in Mississippi.

The Mississippi Health Insurance Claim Form, with few minor exceptions, is similar in format to the HIC form developed by the Council on Medical Service of the AMA in cooperation with the insurance industry. The form consists of 31 items of information, 13 of which can be completed by the patient. It replaces the multitude of health insurance forms with accompanying instructions presently used in the state. Implementation of the form has been a top goal of the association for several years. Only Oregon presently requires a uniform HIC form.



HEALTH INSURANCE CLAIM FORM

Read instructions on back before completing form

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ COMPANY NAME

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. Patient's Name (First name, middle initial, last name)
2. Patient's Date of Birth
3. Insured's Name (First name, middle initial, last name)
4. Patient's Address (Street, city, state, ZIP Code & Phone No.)
5. Patient's Sex — MALE FEMALE
6. Insured's I.D. No. or MEDICARE or MEDICAID No. (Include any letters)
7. Patient's Relationship to Insured — Self Spouse Child Other
8. Insured's Group No. (Or Group Name)
9a. Patient's Other Health Coverage or Insurance Name & Address of Other Plan or State Assistance
10. Was Condition related to: A. Patient's Employment — YES NO; B. An Auto Accident — YES NO
11. Insured's Address (Street, City, State, ZIP Code)
9b. Name of Employer/Organization Providing Other Coverage
9c. Policy or Medical Assistance No.
9d. Name of Person Insured Under Other Plan
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I Authorize Release of Any Medical Information Necessary to Process this Claim. If This is a MEDICARE or CHAMPUS Claim, I Request Payment to Myself or to the Party Who Accepts Assignment Below. Signed Date
13. I certify that the foregoing statements are true and correct. I do ☐ do not ☐ authorize payment of medical benefits to undersigned physician or supplier for services described below. Signed (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. Date Of: Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)
15. Date First Consulted You For This Condition
16. Has Patient Ever Had Same or Similar Symptoms? YES NO
17. Name of Referring Physician
18. For Services Related to Hospitalization give Hospitalization dates: Admitted Discharged
19. Name & Address of Facility Where Services Rendered (If other than home or office)
20. Was Laboratory Work Performed Outside your Office? YES NO Charges
21. Diagnosis or Nature of Illness or Injury. Relate Diagnosis to Procedure in Column D by reference to Numbers 1, 2, 3, Etc. or DX Code
1
2
3
4

22 A Date Of Service	B Place of Service	C Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given: Procedure Code (Identify)	(Explain Unusual Services or Circumstances)	D Diagnosis Code	E Charges	F LEAVE BLANK

23. Signature of Physician or Supplier (Read back before signing) Signed Date
24. Accept Assignment (Government Claims Only) (See Back) YES NO
25. Total Charge
26. Amount Paid
27. Balance Due
28. Your Social Security No.
29. Physician's or Supplier's Name, Address, Zip Code & Telephone No.
30. Your Patient's Account No.
31. Your Employer I.D. No. I.D. No.

*PLACE OF SERVICE CODES
1 — (IH) - Inpatient Hospital; 2 — (OH) - Outpatient Hospital; 3 — (O) - Doctor's Office; 4 — (H) - Patient's Home; 5 — Day Care Facility (PSY); 6 — Night Care Facility (PSY); 7 — (NH) - Nursing Home; 8 — (SNF) - Skilled Nursing Facility; 9 — Ambulance; O — (OL) - Other Locations; A — (IL) - Independent Laboratory; B — Other Medical/Surgical Facility

Official Standard Insurance Form approved in compliance with H.B. 290, 1974 Regular Session, Miss. Legislature, an act amending Section 83-9-13, Miss. Code of 1972

Mississippi's uniform health insurance claim form.

UMC Surgical Forum Set for March

Surgeons from throughout the United States will participate in the second annual postgraduate surgical forum at the University of Mississippi Medical Center in Jackson Mar. 13-15, 1975.

Participants will hear 11 internationally known surgeons discuss the latest advances in gastrointestinal, endocrine, colon, pancreas, and breast surgery.

Dr. James D. Hardy, University of Mississippi School of Medicine professor of surgery and chairman of the department, and Dr. William O. Barnett, professor of surgery, are coordinating the event. Sponsors are the UMC Division of Continuing Health Professional Education and the School of Medicine Department of Surgery.

Advance registration with $150.00 fee should be addressed to the Division of Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson 39216. Enrollment is limited to 200.

Head and Neck Tumor Clinic Established

Effective Nov. 1, 1974, all adult patients at the University Medical Center and the Veterans Administration Hospital in Jackson with tumors involving the scalp, nose (internal and external), ear, lips and oral cavity, nasopharynx and oropharynx, larynx and cervical esophagus will be followed and treated by a multidisciplinary team consisting of general, otolaryngic, and plastic surgeons, radiotherapists, medical oncologists, oral surgeons, prosthetists, and general dentists.

The purposes of establishing this clinic shall be as follows:

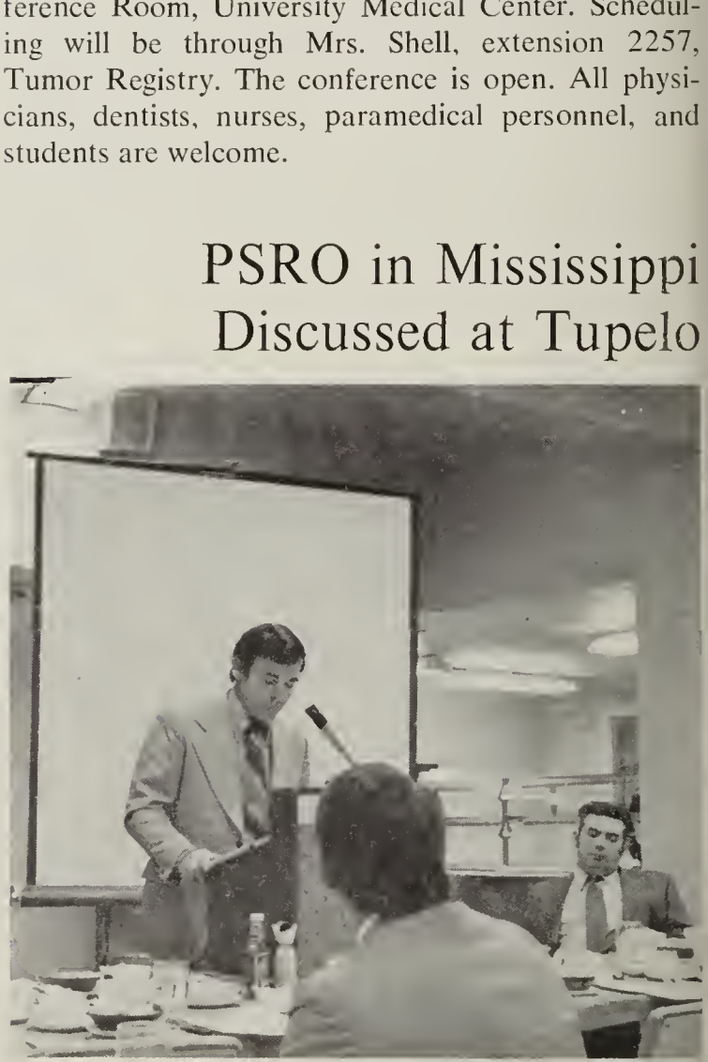
1. To accurately examine, stage, record, and catalogue all new primary tumors for future research efforts
2. To plan and execute a coordinated treatment program so as to utilize the talents of all the represented disciplines to achieve the overall goal of therapy
3. To consolidate all patients in one area so as to provide expert and interested teaching capability for students, residents and practicing physicians, as well as nursing and paramedical personnel
4. To provide the mechanism for continuum of care between the treatment team in the hospital and the family physician

The following data is for referral purposes:

	University Medical Center	*V. A. Hospital*
Place	Clinic 4	ENT Clinic
Day	Wednesday	Wednesday
Time	8:30-10:00	2:00-3:30
Tumor Conference	11:00-12:00	3:30-4:00

Interesting patients will be presented at Tumor Conference at 11:00 a.m. in the Research Conference Room, University Medical Center. Scheduling will be through Mrs. Shell, extension 2257, Tumor Registry. The conference is open. All physicians, dentists, nurses, paramedical personnel, and students are welcome.

PSRO in Mississippi Discussed at Tupelo



Dr. James W. Rayner of Oxford, member of the Executive Committee of the Mississippi Foundation for Medical Care, is shown describing the Mississippi Professional Standards Review Organization program (PSRO) at a recent meeting of the medical staff at the North Mississippi Medical Center in Tupelo. Members of the Executive Committee are appearing before hospital medical staffs, on request, throughout the state to discuss PSRO implementation in Mississippi.

Thoracic Society Holds Annual Meeting-Seminar

Over 125 Mississippi physicians, inhalation therapists, and medical students attended the Mississippi Thoracic Society Annual Meeting-Pulmonary Seminar held Oct. 10 at the University Medical Center.

Guest speaker Dr. Alan K. Pierce, faculty member of the Department of Medicine, Southwestern Medical School, Dallas, lectured on the theme of the scientific session, "A New Look at the Obstructive Lung Syndrome."

Other speakers for the one-day event included members of the University Medical Center faculty: Dr. Bernard H. Booth, clinical assistant professor of medicine; Dr. A. Wallace Conerly, assistant professor of medicine and director of respiratory therapy; Miss Sharon Hawley, R.P.T., Department of Anesthesiology; Dr. Joe R. Norman, professor of medicine, director of the Division of Pulmonary Medicine, and Mississippi Lung Association Christmas Seal Professor of Respiratory Diseases; and Dr. G. Boyd Shaw, clinical assistant professor of medicine.

Titles of papers presented include: "Obstruction and Lung Function Testing," "The Clinical Application of Arterial Blood Gases," "The Asthmatic in the Office," "Prevention of Postoperative Pulmonary Complication," "A Practical Demonstration of Pulmonary Physical Therapy," "Home Inhalation Therapy" and "The Bronchitic in the Office." Grand rounds were conducted during the noon hour.



Dr. Alan K. Pierce (center) of Southwestern Medical School, Dallas, was the featured speaker at the recent Annual Meeting-Seminar held at the University of Mississippi Medical Center. Dr. John R. Williams (left) of Greenville is the newly-elected president and Dr. Fred R. Tatum (right), outgoing president, presided over the special day-long event.



Dr. Alan K. Pierce, center, is shown with Dr. Guy Campbell, left, UMC professor of medicine and chief of the Division of Chest Diseases at the VA Hospital, and Dr. Richard Furr of Ocean Springs, MTS secretary/treasurer.

The scientific section of the society's meeting was jointly sponsored by the Mississippi Lung Association, the University of Mississippi Medical Center School of Medicine and Division of Continuing Health Professional Education. The Mississippi Thoracic Society is the medical section of the Mississippi Lung Association.

The seminar was concluded with the annual Thoracic Society business meeting. Officers elected for the coming year are: Dr. John R. Williams, Greenville, president; Dr. Walter Treadwell, Jackson, president-elect; and Dr. Richard Furr of Ocean Springs, secretary-treasurer.

Dr. Williams announces two forthcoming events. The 19th Annual Tri-State Thoracic Society Consecutive Case Conference sponsored by Thoracic Societies and Lung Associations of Alabama, Louisiana and Mississippi will be held Jan. 17-18. 1975, at the Sheraton Biloxi Hotel, Biloxi. The First LAMOT Pediatric Pulmonary Conference, sponsored by Thoracic Societies and Lung Associations of Louisiana, Arkansas, Mississippi, Oklahoma and Texas, will be held July 18-19, 1975, at Chateau Motor Hotel, Shreveport, La. Each session, with a registration fee of $10, is designed to serve as a postgraduate training opportunity for physicians, residents and interns.

For further information, contact the Mississippi Lung Association, Post Office Box 9865, Jackson, MS 39206.

PSRO Reports on Development in State

The Mississippi Foundation for Medical Care—Professional Standards Review Organization (PSRO) has completed planning for phasing in PSRO review activities in Mississippi hospitals beginning in February 1975.

In other activities the foundation is surveying each Mississippi hospital by mail to determine current professional review activities and members of the foundation's PSRO Executive Committee continue to meet with hospital medical staffs on request to review and discuss PSRO implementation plans.

Members of the foundation have recently nominated and elected a Board of Directors by mail ballot. Physicians elected to the board are:

Drs. Robert S. Caldwell, Tupelo; Robert F. Carter, Jr., Biloxi; Millard S. Costilow, North Carrollton; Joe S. Covington, Meridian; Everett Crawford, Tylertown; J. P. Culpepper, III, Hattiesburg; J. T. Davis, Corinth; Arthur A. Derrick, Jr., Durant; Gerald P. Gable, Hattiesburg; Lyne S. Gamble, Greenville; James O. Gilmore, Oxford; Sidney O. Graves, Jr., Natchez; Whitman B. Johnson, Jr., Clarksdale; Tom H. Mitchell, Vicksburg; Kenneth P. Pittman, Jackson; William H. Preston, Jr., Booneville; James W. Rayner, Oxford; James L. Royals, Jackson; C. D. Taylor, Jr., Pass Christian; and James T. Thompson, Moss Point.

AMA Is Updating Medicredit

The American Medical Association is now in the process of reviewing and updating its position on national health insurance in anticipation of National Health Insurance being a top priority when the 94th Congress convenes in January.

"Our objective is to make the AMA's national health insurance proposal more flexible while at the same time maintaining certain basic precepts," stated AMA president Malcolm C. Todd.

"If necessary, we may compromise on the method of financing we adopt. But we are not willing to fund national health insurance through an increase in social security taxes nor are we willing to see the program administered by the Social Security Administration.

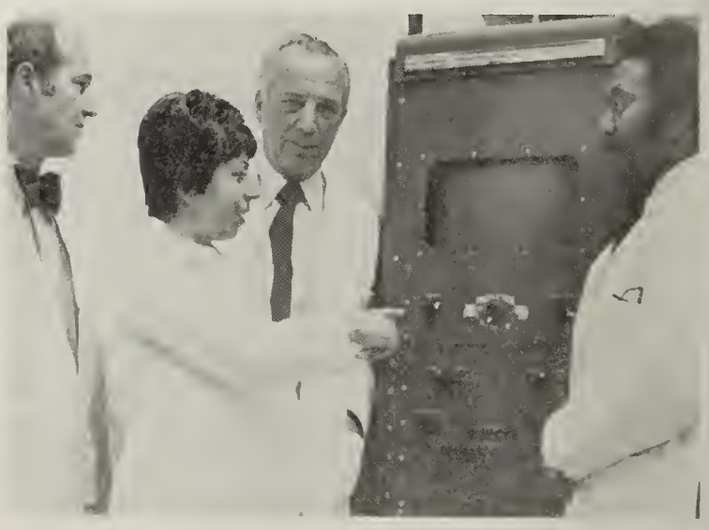
"We want a financing mechanism for comprehensive health insurance that will do the most at the least cost. This could involve: increase employer-employee contributions for private health insurance; the use of general tax revenues; or, an individual tax credit to be applied toward full health care protection. This latter method was, of course, the method employed in Medicredit.

"The important point is that we cannot countenance greater fiscal and bureaucratic authority for the Social Security Administration or an increase in the social security tax.

"Any payroll tax, whether collected under social security or not, constitutes the most insidious form of taxation that can be invoked by government. It is a totally regressive tax that weighs heavily on low and middle income workers and lightly on the affluent.

"Finally, the measure that emerges will provide comprehensive health care benefits as well as protection against the catastrophic costs of prolonged illness for every American," Dr. Todd said.

Medical Center Sponsors EKG Course



Eight Mississippi physicians participated in the early October one-week intensive course in EKG at the University of Mississippi Medical Center. Registrants included, from left, Dr. John E. Harris of Okolona, Dr. N. E. Murillo Smith of Meridian, Dr. Hubert F. Campbell of Wiggins, and Dr. Albert Britton of Jackson. The EKG course is one of six one-week intensive sessions the UMC Division of Continuing Health Professional Education offers this fall.

Material on Smoking Is Now Available

Five member organizations of the Mississippi Interagency Council on Smoking and Health are offering smoking and health presentations to schools, civic groups and organizations, according to B. G. Garrison, president of the council and health educator for the Mississippi State Board of Health.

The Mississippi Division of the American Cancer Society, the Mississippi Heart Association, the Mississippi Lung Association, the Mississippi Cooperative Extension Service and the Mississippi State Board of Health are the five organizations offering the presentations.

The Interagency Council is composed of 21 organizations in the state interested in the problem of tobacco smoking. The council is a means of coordinating anti-smoking efforts and resources to the schools of Mississippi and the general public.

"These organizations will be glad to provide information, speakers and other educational material to any group in the state," Garrison said.

"Interested parties may contact any of these five organizations if they desire such a program for their church, school, or civic organization," Garrison said.

The Mississippi Division of the American Cancer Society has educational leaflets, posters, mannequins and films. Contact Elizabeth Johnson, 354 North Mart Plaza, Jackson, MS 39206, phone 362-8514.

The Mississippi Heart Association has educational leaflets, posters, films and can arrange for speakers. Contact Betty Bunner, 4830 East McWillie Circle, Jackson, MS 39211, phone 362-6945.

The Mississippi Lung Association has educational leaflets, posters, films, and mannequins for programs. They also have speakers. Contact Martha Monaghan, 353 North Mart Plaza, Jackson, MS 39206, phone 362-5453.

The Mississippi Cooperative Extension Service has literature, films, educational materials and speakers can be arranged through 4-H counselors. Contact Linda Ogle, Mississippi State University, P. O. Box 5406, Mississippi State, MS 39759, phone 325-4634.

The Mississippi State Board of Health has a mannequin, educational films, leaflets, posters and actual lung tissue to demonstrate the effects of cigarette smoke on the lungs. Contact B. G. Garrison, P. O. Box 1700, Jackson, MS 39205, phone 354-6680.

Top Cancer Researcher Visits UMC



Dr. Ingegerd Hellstrom, internationally known cancer researcher who with her husband, Dr. Karl Erik Hellstrom, this year received the American Cancer Society's top award for excellence in research, opened guest lectures at the Southeastern Immunology Workshop in Jackson. The University of Mississippi Medical Center hosted the event, and professor of surgery (research) Dr. Jack Grogan, left, served as coordinator.

'Feeling Good' Is New Health Care Show

"Feeling Good," CTW's new prime-time series on health care for adults, premiered on the 250 stations of the Public Broadcasting Service Nov. 20.

The experimental series—26 hour-long shows to be broadcast each week for a full year—has been characterized as television's most ambitious attempt to both inform people and motivate them toward healthier living.

It is the first program to be created for adults by CTW, pioneers of such successful TV productions as "Sesame Street" and "The Electric Company."

"Feeling Good" will employ a variety-magazine format using animation, song, dance, comedy and documentaries to treat 11 priority health topics: alcohol abuse, cancer, child care, exercise, dental care, the health care delivery system, heart disease, hyper-

tension, mental health, nutrition and prenatal care.

Each topic will be treated several times during the series' first year.

Several informational and behavioral goals have been developed for each topic. The aim is to inform people about the symptoms and methods of avoiding various health problems and to motivate them to take some actions in preventing their occurrence or to decrease their danger.

The underlying philosophy of "Feeling Good" is that people have more control over their health than they realize. The show will point out some of the fundamentals of good health and then will pinpoint how people's actions play an important role in the kind of health they enjoy.

Primary target audience for the series is young parents who play major roles in influencing the health of their immediate families. Of particular concern to the producers are the health problems of low-income families.

Major underwriters are the Corporation for Public Broadcasting, the Robert Wood Johnson Foundation, Exxon Corporation and the Aetna Life and Casualty Co.

The series will use a resident company of six performers who congregate at "Mac's Place"—a variety store in a shopping center. The characters include Mac, the owner; a resident at a nearby hospital and his wife, an exercise instructor; an elderly woman who frequently visits Mac's; a young waitress raising her nine-year-old child alone; and the middle-aged owner of a sporting goods store.

In addition to the regular cast, Bill Cosby will appear as a regular guest star and celebrities such as Pearl Bailey, Johnny Cash, B. B. King, Helen Reddy, and Bob and Ray will show up in cameo appearances.

CTW's staff began its investigation of the potential of the series in 1972 by interviewing health experts from all parts of the country to determine pressing health problems and to discover the extent to which TV might play a part in lessening them. Then came a series of nine seminars in 1973 which focused on certain crucial health topics.

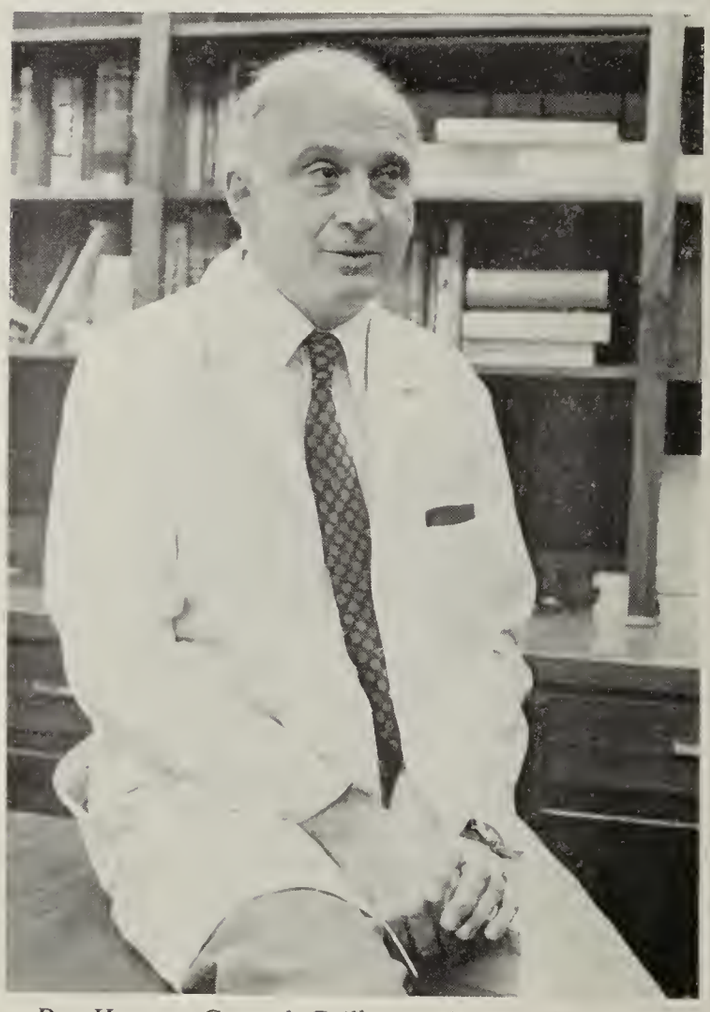
The experts agreed that TV has an immense untapped potential not only for providing vital health information, but also for helping people to make use of this information in their daily lives.

Much of the advice given CTW underscored the point that health education depends not merely on the *transmission* of information but also on *motivating* individuals to make use of the information in their daily lives.

"Too many people," says Dr. J. Robert Buchanan, chairman of the series' national advisory council, "regard good health as a birthright for which they have little or no continuing responsibility. Illness, on the other hand, is frequently denied, or if it's acknowledged, the patient commonly hastens to transfer total responsibility for dealing with it to someone else, usually a physician. Moreover, there is a common failure to recognize the relationship between an individual's way of life and the kind of health he or she enjoys."

The new health series for adults will air each week at 7:00 p.m. Wednesday and also at 11:30 a.m. Friday and 2:30 p.m. Sunday on Mississippi EVT Channels 19, Biloxi; 12, Booneville; 17, Bude; 23, Greenwood; 29, Jackson; 14, Meridian; 2, Mississippi State and 18, Oxford-University.

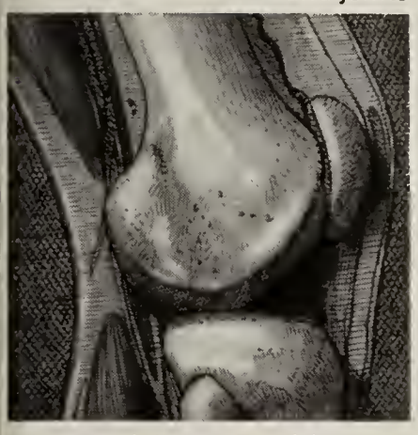
Harvard Surgeon Visits UMC



Dr. Hermes Conrad Grillo, professor of surgery at Harvard Medical School and chief of general thoracic surgery at Massachusetts General Hospital, was visiting professor at the University of Mississippi Medical Center in October. Dr. Grillo met with faculty, house staff, and students while at UMC and was guest speaker for the regular UMC Center Assembly on Friday.

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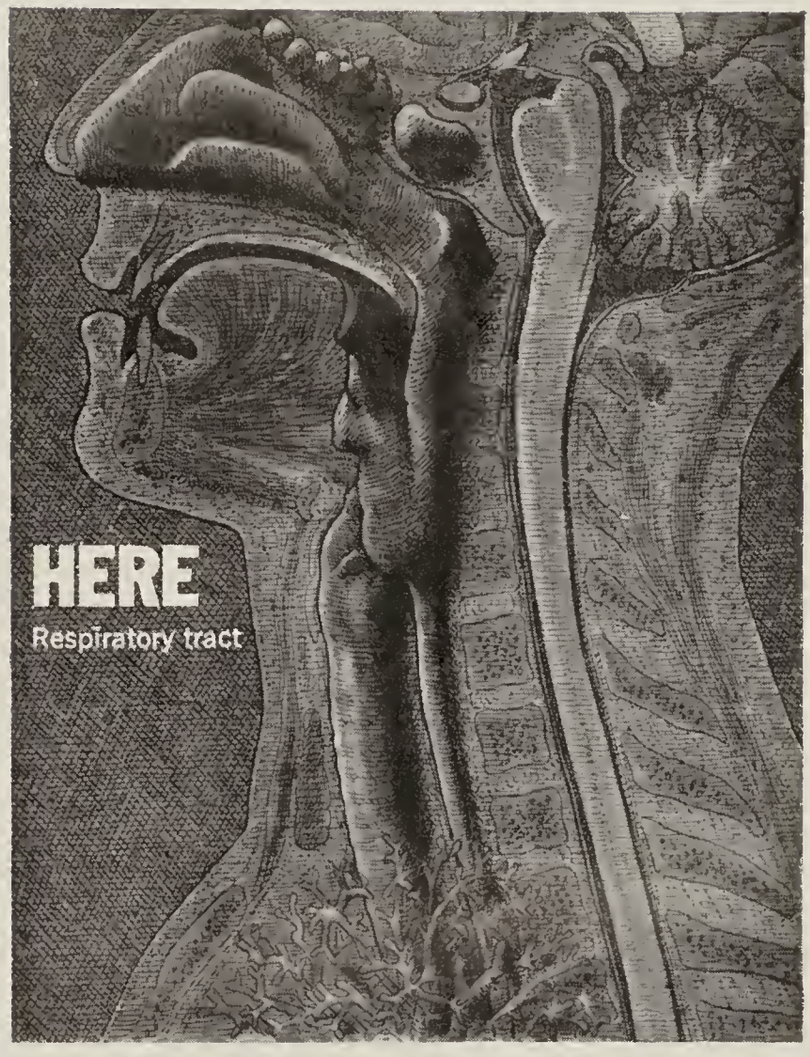
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1975 MSMA-Robins Award Is Announced

The fourteenth annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1975 award will be presented at the 107th Annual Session during closing ceremonies on May 8.

Dr. J. T. Davis, president, and Dr. James O. Gilmore, chairman of the Board of Trustees, said that each component medical society had been invited to submit a nomination for the honor. The award is cosponsored annually by the association and the A. H. Robins Company of Richmond, Va., a long-established manufacturer of ethical pharmaceuticals.



MSMA-Robins Award

Drs. Davis and Gilmore said that nominees must be members of the state medical association and that the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in this connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural, or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Drs. Davis and Gilmore said that each letter of nomination must be signed by an officer of the component medical society. Nominations from previous years may be resubmitted.

Deadline for submission of nominations to the state medical association is Jan. 1, 1975. Each nomination will be acknowledged, and the Board of Judges, consisting of the three MSMA vice presidents, will review the nominations.

The Robins series was instituted in 1962, and the award consists of a sculptured bronze plaque in *bas* relief, engraved, and mounted on a mahogany panel.

The 13 Mississippi physicians who have received the high honor are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell of Ellisville, by the South Mississippi Medical Society in 1965.

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by Delta Medical in 1967; Dr. W. H. Anderson of Booneville, by Northeast in 1968; Dr. Omar Simmons of Newton, by the East Mississippi Medical Society in 1969; Dr. W. J. Aycock of Calhoun City, by the Northeast Society in 1970; Dr. Walter H. Rose of Indianola, by Delta Medical in 1971; Dr. Reginald P. White of Meridian, by the East Mississippi Medical Society in 1972; Dr. W. A. Long, Jr., of Jackson, by the Central Medical Society in 1973; and Dr. Virginia S. Tolbert of Ruleville, by Delta Medical Society in 1974.

Tri-State Thoracic Conference Set

Thirteen speakers from medical centers throughout the U. S. will be featured at the 19th Annual Tri-State Thoracic Consecutive Case Conference to be held Jan. 17-18 at the Sheraton Hotel in Biloxi.

Dr. John R. Williams of Greenville, president of the Mississippi Thoracic Society, announced that the two-day event, designed to serve as a postgraduate training session for physicians, residents and interns, will be sponsored by the Lung Associations and Thoracic Societies of Mississippi, Louisiana and Alabama.

Mississippi physicians featured on the program include Dr. Bernard H. Booth, Dr. Guy Campbell and Dr. G. Boyd Shaw, all of Jackson. Dr. Walter Treadwell of Jackson, secretary of the MTS and program chairman for Mississippi, will also serve as moderator.

Topics of special interest to thoracic specialists include: "Interstitial Pneumonitis," "Extra Manifestations of Lung Cancer," "Anaerobic Pleuro-Pulmonary Infections," "The Lung as a Mirror of Systemic Disease," "Allergic Lung Disease," "Use of the Transbronchial Biopsy Technique in Diagnosis of Sarcoid" and "Challenging Cases in the Practice of Radiology."

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The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR," Book Review; "CPC," Clinicopathological Conference; "MLB," Medico-Legal Briefs; "AP," Auxiliary Page; the asterisk (*) indicates an original article in the JOURNAL, and the author's name follows the entry in brackets. "Deaths," "Personals," and "New Members" are indexed under the letters "D," "P," and "M" respectively.

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IN CONCLUSION

Ascorbic acid may be necessary in larger doses than that required for prevention of scurvy. In studies on guinea pigs it was found that those given 100 times the minimum showed better tissue integrity in epithelial cells of the buccal cavity. This seems to support Linus Pauling's contention that such doses may be beneficial. Vitamin C may be necessary to enhance integrity and function of the tonofilament-desmosome systems with the epithelial cells.(AM.J.Clin.Nutr.)

Females in the general population of the U.S. have lower mortality than males do throughout the life cycle, according to Metropolitan Life's Statistical Bulletin. Mortality among women from diseases of the heart, the leading cause of death for both sexes, was only half that among men at all ages combined. Among women, mortality from external causes--accidents, suicide, and homicide--was approximately a third of that for men, according to recent studies.

According to a government report, production of bulk medicinal chemicals in 1973 amounted to 233.6 million pounds or 0.3% less than 1972 production, but 4.6% more than 1971 output. Sales, however, were 18.8% higher in 1973 than in 1972. Physical production of antibiotics increased to 20.8 million pounds, while anti-infectives other than antibiotics fell 3.4%, to 33.2 million pounds. Vitamins showed an increase of 13.3%.

A reference booklet on the federal diagnostic X-ray equipment standard is now available from the Food and Drug Administration's Bureau of Radiological Health. The 10-page booklet "A Practitioner's Guide to the Diagnostic X-ray Equipment Standard," was prepared primarily with the needs of X-ray equipment users and owners in mind. Single free copies of the guide are available from the Bureau of Radiological Health, 5600 Fishers Lane, Rockville, Md. 20852.

The AMA's new program of regional continuing education for physicians will be launched next year with meetings in Florida, Arizona, Minnesota and Virginia. Purpose of the program, which will be conducted by the Council on Scientific Assembly, is to take AMA continuing education courses to physicians throughout the country. Courses will be held on weekends to enable MDs in each region to attend at the lowest possible cost in time and travel expenses.

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